SPEAR WILDERMAN PC
BENJAMIN EISNER
MARTIN W. MILZ
230 S. Broad Street, Suite 1400
Philadelphia, PA 19102
Attorneys for Plaintiffs Sheet Metal Workers' Local 19, et al.

IN THE UNITED STATES DISTRICT COURT
FOR THE EASTERN DISTRICT OF PENNSYLVANIA

SHEET METAL WORKERS' LOCAL 19 **1301 S. Columbus Boulevard** **Philadelphia, PA 19147** **and** **KELLI-ANNE FREY** **JASON FREY** **110 Freedom Court** **Bethlehem, PA 18020** **Plaintiffs,** **v.** **STERIS Corporation** **5960 Heisley Road** **Mentor, OH 44060-2600** **and** **STERIS Corporation Welfare Benefit Plan** **5960 Heisley Road** **Mentor, OH 44060-2600** **and** **Controlled Environment Certification Services, Inc. dba Micro Clean** **177 North Commerce Way** **Bethlehem, PA 18017** **Defendants.**	:	**CASE NO.**

VERIFIED COMPLAINT

Preliminary Statement

This is an action to prevent and reverse the wrongful termination by Defendant STERIS Corporation of the group health benefits of twenty-eight of its employees during a lawful strike, in violation of both STERIS' own group health benefit plan document and its fiduciary and administrative duties under ERISA. The Employer has failed even the fundamental step of sending COBRA notices, producing confusion and further endangering the affected employees. STERIS is an international enterprise, listed on the New York Stock Exchange, which does business in this judicial district through its subsidiary, Controlled Environment Certification Services, Inc., also known as Micro-Clean.

Plaintiff Sheet Metal Workers' Local 19 represents the injured STERIS employees, including Plaintiffs Kelli-Anne and Jason Frey, who are threatened with irreparable injury if their group health benefits are terminated. The Union has filed parallel Unfair Labor Practice Charges with the National Labor Relations Board in connection with the benefit termination, asserting that STERIS is retaliating against its employees for engaging in a lawful strike. This charge will be investigated by the Board in the normal course, but in the meantime, these STERIS employees have lost or will lose their health coverage.

Plaintiffs therefore seek immediate, preliminary and permanent equitable relief enjoining the termination of benefits, thereby protecting vital medical treatment on which the employees depend, and preventing immediate and irreparable harm that will result from the Defendant Employer's unlawful benefit termination. Immediate injunctive relief will likewise preserve the

status quo until both the Board and this Court can review fully and respond to the Defendant Employer's discriminatory and unlawful actions.

The Parties

1. Plaintiff Sheet Metal Workers' Local Union 19 ("Local 19" or the "Union") is a labor organization, with its address at 1301 South Columbus Boulevard, Philadelphia, PA 19147, which is within the Eastern District of Pennsylvania. Local 19 is a local affiliate of the International Association of Sheet Metal, Air, Rail and Transportation Workers. It represents employees in, among other industries, heating, ventilation and air conditioning systems ("HVAC"), including cleanroom-related work. STERIS's employees who are represented by Local 19 perform such cleanroom-related work. Local 19 is a Plaintiff in its capacity as a representative of the twenty-eight STERIS employees, including Plaintiff Jason Frey and his co-workers, who are affected by the Employer's unlawful benefit termination (the "Employees").

2. Plaintiffs Kelli-Anne Frey and her husband Jason Frey are participants in the Employer STERIS's group health plan. The Freys live with a number of health issues that require constant medical attention and treatment, including Ms. Frey's acute idiopathic hypoglycemia. The Freys sole health care coverage for these conditions comes from the STERIS group health plan (as defined further below). The Freys are participants and beneficiaries of the STERIS group health plan pursuant to ERISA sections 3(7) and 3(8). Mr. Frye is an employee of STERIS/Micro-Clean and a member of Local 19.

3. Defendant STERIS Corporation ("STERIS" or "Employer") is the employer of Plaintiff Jason Frey and of the Employees. It also serves as the Sponsor and Plan Administrator

of the STERIS Corporation Welfare Benefit Plan. Exhibit A (Summary Plan Description), at 2, 16. In its capacity as Plan Administrator, STERIS is a fiduciary of the STERIS Corporation Welfare Benefit Plan. *Id.* STERIS does business internationally, describing itself as "a global leader in infection prevention, contamination control and surgical care technologies." Exhibit B (portion of STERIS homepage.) STERIS is an Ohio corporation. Although it maintains business locations throughout the United States and the world, its principal address is 5960 Heisley Road, Mentor, Ohio, 44060-2600.

4. Defendant Controlled Environment Certification Services, Inc., dba Micro Clean, ("Micro-Clean"), a subsidiary of STERIS, is likewise an Ohio corporation, and with STERIS employs the Employees. STERIS conducts business within this judicial district through Micro-Clean, which operates at 177 North Commerce Way, Bethlehem, PA 18017, within the Eastern District of Pennsylvania.

5. Defendant STERIS Corporation Welfare Benefit Plan ("Plan") is a welfare benefit plan within the meaning of Section 3(1) of ERISA providing medical, surgical, hospital, dental, vision and other health benefits to employees of STERIS and "its participating affiliates," pursuant to a plan of benefits adopted by the STERIS Corporation, the Plan's sponsor. Exhibit A (Plan Summary Plan Description) at 1. The Freys, the Employees and their families are participants and/or beneficiaries of the Plan, and rely on the benefits provided by the Plan. Although the Plan can be found in this District, its business address is STERIS Corporation, 5960 Heisley Road, Mentor, OH 44060-1834.

Jurisdiction

6. This suit is brought pursuant to Section 502(a)(3) of the Employee Retirement Income Security Act of 1974, as amended, (ERISA) 29 U.S.C. § 1102 (a)(3) , and Section 302 of the Labor Management Relations Act, (LMRA) 29 U.S.C. §186, to enjoin the termination of the Employees' benefits in violation of both the STERIS Corporation Welfare Benefit Plan and of ERISA. Plaintiffs also invoke the Court's jurisdiction under 28 U.S.C. §1331.

Venue

7. Both the Defendants and Plaintiffs can be found in this judicial district. Venue is thus appropriate in the United States District Court for the Eastern District of Pennsylvania.

Statement of Facts – Eligibility for Benefits Under the Plan

8. STERIS established the Plan to provide "welfare benefit options" to its employees, including "medical, dental, prescription drug, AD&D, long-term disability, group term life insurance..." and other welfare benefits. *Id.* at 2.

9. Eligibility for group health benefits is provided to "regular employee[s]...as soon as 30 days from your date of hire." Exhibit C, at 2 (STERIS 2016 Health Plan Benefit Eligibility and Enrollment booklet); Exhibit A at 3 (incorporating, under the heading "Eligibility," "the information contained in the Booklets issued by the insurer or the Company, for that benefit option.").

10. Termination of benefit eligibility occurs "when your employment terminates with your Employer...[and] may also terminate if you fail to pay your share of premium." Exhibit A at

3. As it must, the Plan provides for continuation coverage and the sending of COBRA notices upon benefit termination. *Id*, at 13-14.

11. The Employees have been and remain regular employees of the Employer. They similarly have been and remain Participants under the Plan. At all relevant times prior to the Employer's actions seeking to terminate benefits as described in this Complaint, the Employees were eligible for benefits under the Plan.

12. As required by the terms of the Plan, each of the Employees has paid his or her "share of [group health plan insurance] premium" to maintain benefit eligibility under the Plan both before and after the initiation of the Strike. *See* Exhibit C at 3 ("2016 Medical Weekly Employee Payroll Deductions"). Payments after the initiation of the Strike have been made by delivery of the required amount to the Employer, rather than by payroll deduction. Exhibit D (one example of a cover letter for payments made by each of the Employees).

Statement of Facts – Collective Bargaining

13. On June 2, 2016 the Employees voted overwhelmingly to be represented by Local 19 for the purpose of bargaining a collective bargaining agreement.

14. Local 19 and STERIS have negotiated over the terms and conditions of the Employees' employment to achieve a collectively bargained agreement for more than six months.

15. On or about February 16, 2017 the negotiations broke down and the Employees declined to continue to work, thereby initiating a strike against the Employer (the "Strike"). The Employees remain on strike at this time. No additional negotiations between Local 19 and STERIS are scheduled.

Statement of Facts – STERIS Terminates Group Health Benefits

16. In response to and in retaliation for the Strike, the Employer terminated the Employees' eligibility for benefits under the Plan. *See* Exhibit E (2.16.17 memo of STERIS Vice President Mike Briglia stating "striking employees ... do not receive Company-paid benefits such as medical insurance").

17. The Employer has, however, failed in patent violation of the COBRA regulations, ERISA sections 601-609, 29 USC §§ 1161-1169, to provide written notice to each of the Employees or to Local 19 of the effective date of benefit termination, or to respond in writing to specific inquiries of its intentions regarding a termination date. Exhibit F (letter to Employer seeking clarification).

18. Confusion, even chaos, has ensued. Because they were without knowledge of the Employer's precise intentions regarding termination of Plan benefit eligibility, the Employees generally have been forced to learn about benefit termination from their health care providers, and have been unable even to secure continuing benefits through COBRA.

19. Ms. Frey, for instance, learned that her benefits had been terminated when her pharmacy declined to fill a prescription at the cost of her ordinary co-pay.

20. On February 24, 2017, Employer and Plan Representative Kathy Savage informed Plaintiff Jason Frey orally that Plan benefit eligibility for the Employees terminated February 16, 2017, the date the Strike began. Still, no COBRA notices have been issued.

First Cause of Action – Benefit Termination in Violation of the Terms of the Plan – ERISA section 502(a)(1)(B).

21. The Plaintiffs hereby incorporate by reference paragraphs 1 through 20 of this Complaint.

22. Under the Plan regular employees of the Employer remain eligible for benefits so long as they pay their "share of any premium." *See* Exhibit A at 3 and Exhibit C at 3.

23. The Employees remain regular employees of the Employer both before and during the Strike.

24. On February 24, 2017 Ms. Savage confirmed the Employer's and the Plan's agreement as to continuing status of the Employees as regular employees of the Employer.

25. The Employees have paid their "share of any premium" both before the Strike, by payroll deduction, and during the Strike both by payroll deduction and by delivering the payment to the Employer. Exhibit D (direct payment cover letter).

26. On February 24, 2017 the Employer accepted the Employees' payment of their share of any unpaid premium during the Strike.

27. The Employer's termination of the Employees' benefit eligibility under the Plan thus violates the Plan's express terms. The failure to send COBRA notices likewise violates the Plan.

28. Termination of Plan group health benefits threatens irreparable harm to the Employees. The Employees' benefit status is unclear, producing chaos and confusion.

29. In particular, but without limitation, Ms. Frey is receiving on-going treatment for potentially life-threatening hypoglycemia, but has been denied medical benefits.

30. Benefit eligibility termination threatens the vital medical treatments and the sensitive and confidential doctor-patient relationships of all of the Employees. If eligibility termination is permitted, Plaintiffs and the affected participants will be injured immediately and irreparably.

31. Plaintiffs have no adequate remedy at law. Any appeal that might be available under the Plan is futile.

WHEREFORE, Plaintiffs request that this Court enter judgment against Defendant:

1) immediately, preliminarily and permanently enjoining the Defendant Employer and Plan from terminating the Employees' benefit eligibility;

2) awarding attorney's fees and costs; and

3) providing such other relief as the Court may find equitable and just.

Second Cause of Action – Breach of Fiduciary Duty and of COBRA – ERISA sections 404(a)(1), (a)(1)(B) and (a)(1)(D), and 601-609

32. The Plaintiffs hereby incorporate by reference paragraphs 1 through 31 of this Complaint.

33. As Administrator of the Plan, STERIS is a fiduciary under ERISA, and makes benefit determinations, and is responsible for sending COBRA notices. Exhibit A, at 16.

34. As an ERISA fiduciary, STERIS must administer the Plan "solely in the interest of the participants and beneficiaries" of the Plan. ERISA § 404(a)(1).

35. Moreover, as an ERISA fiduciary, STERIS must "discharge its duties with respect

to [the] [P]lan ... in accordance with the documents and instruments governing the Plan..." ERISA § 404(a)(1)(D).

36. The Plan does not provide for, or permit, benefit termination during a lawful strike by STERIS's regular employees who continue to pay their portion of any premium.

37. STERIS in its capacity as Plan Administrator and fiduciary nevertheless terminated the benefit eligibility of the Employees, and even has failed to send COBRA notices.

38. STERIS took this action to further its managerial interests in the labor negotiations and the Strike, and/or neglected to review the Plan carefully.

39. STERIS thereby violated ERISA section 404 and sections 601-609. It also violated the National Labor Relations Act, compelling Local 19 to file an Unfair Labor Practice Charge with the National Labor Relations Board. (Exhibit G). These actions injured the Employees, including Plaintiffs Jason and Kelli Frey, and threaten the Freys and all of the Employees with immediate and irreparable harm through the loss of group health benefit eligibility.

40. Plaintiffs have no adequate remedy at law.

WHEREFORE, Plaintiffs request that this Court enter judgment against Defendants:

1) immediately, preliminarily and permanently enjoining the Defendant Employers and Plan from terminating the Employees' benefit eligibility;

2) awarding attorney's fees and costs; and

3) providing such other relief as the Court may find equitable and just.

Respectfully submitted,

SPEAR WILDERMAN, PC

Benjamin Eisner
Martin W. Milz
Syretta J. Martin
230 South Broad Street, #1400
Philadelphia, PA 19102

Dated: February 27, 2017

VERIFICATION

I, William C. Dorward, as an Area Marketing Representative of Sheet Metal Workers' Local 19, am authorized to make this verification of the attached Complaint and Exhibits. The foregoing averments of fact within the Complaint and Exhibits are true to the best of my information and belief. I understand that the statements made herein are subject to the penalties of 18 Pa.C.S. Section 4904, relating to unsworn falsification to the authorities.

WILLIAM C. DORWARD
Area Marketing Representative

Dated: 2/27/17

EXHIBIT A

SUMMARY PLAN DESCRIPTION

STERIS CORPORATION WELFARE BENEFIT PLAN

STERIS CORPORATION FLEXIBLE BENEFIT PLAN

STERIS CORPORATION DEPENDENT CARE ASSISTANCE PLAN

January 1, 2015

TABLE OF CONTENTS

SUMMARY PLAN DESCRIPTION

STERIS CORPORATION WELFARE BENEFIT PLAN
STERIS CORPORATION FLEXIBLE BENEFIT PLAN
STERIS CORPORATION DEPENDENT CARE ASSISTANCE PLAN

INTRODUCTION

The following is a Summary Plan Description ("SPD") of the welfare benefit options offered to eligible employees of STERIS Corporation (the "Company") and its participating affiliates (the "Employers") under the STERIS Corporation Welfare Benefit Plan (the "Plan"). The STERIS Corporation Flexible Benefit Plan, intended to qualify under Section 125 of the Internal Revenue Code ("Code"), and the STERIS Corporation Dependent Care Assistance Plan, intended to qualify under Section 129 of the Code are components of the Plan. This SPD has multiple parts:

- This SPD, which contains this Introduction, a list of Important Facts and general information concerning the Plan; and

- The individual booklets, certificates of coverage, or summary descriptions (collectively referred to as the "Booklets"), issued by an insurer and/or an Employer or Third Party Administrator, that provide eligibility requirements and a detailed description of the various benefit options currently available under the Plan. The Booklets specify the class of participants covered and include pertinent information about the filing of claims and other Plan provisions. If there is a discrepancy between this SPD and the Booklets, the Booklets will govern. If there is a discrepancy between the Plan and this SPD, the Plan will govern.

The Plan is the result of streamlining that has been completed with regard to the various welfare benefit options offered by the Company. All of these various options were combined to form the Plan. The benefit options available under the Plan may be provided through the purchase of insurance (fully insured benefit options), or paid from the general assets of the Company (self-insured benefit options), or a combination thereof. When you file a claim for benefits under the Plan, the benefits are payable by an insurer, the Company, or a combination of an insurer and the Company, depending on the benefit.

Your eligibility for benefits under the Plan is not a promise, offer, contract or guarantee of employment. Plan benefits are not vested employee benefits. The Company does not guarantee that you will receive the benefits described in this SPD or the Booklets during your entire employment term.

You may examine or obtain copies of information or documents relating to any part of this Plan upon written request to the Plan Administrator (as described in the Statement of ERISA Rights below). The various benefit options available under the Plan are listed on Appendix A.

IMPORTANT FACTS

Name and Number of Plan:	STERIS Corporation Welfare Benefit Plan (including the STERIS Corporation Flexible Benefits Plan and the STERIS Corporation Dependent Care Assistance Plan) Plan Number 501
Employer, Sponsor, Plan Administrator, and Agent for Service of Legal Process:	STERIS Corporation 5960 Heisley Road Mentor, OH 44060-1834 (440) 354-2600
Employer Identification No.:	34-1482024
Type of Plan:	Welfare benefit plan providing medical, dental, prescription drug, AD&D, long-term disability, group term life insurance, business travel accident insurance, pre-tax health care premiums, health savings account, health care expense accounts, and dependent care expense account.
Plan Year:	A calendar year
Type of Plan Administration:	Insurer Administration, Third Party Administrator, or self-administered, depending on the type of benefit.
Type of Plan Funding:	Premium costs are paid by a combination of Employer and employee contributions. All self-insured benefit options are paid solely out of the general assets of the Employers. All fully insured benefit options are paid solely by the applicable insurance company.
Collective Bargaining Agreements	This Plan is partially maintained pursuant to collective bargaining agreements between the Company and the International Union of Electronic, Electrical, Salaried Machine and Furniture Workers, CWA, Local 86823, Local 560, International Brotherhood of Teamsters, and Teamsters Local 170, of Worcester, Massachusetts.
Other Employers Maintaining the Plan	The participants and beneficiaries may receive from the Plan Administrator, upon written request, information as to whether a particular Employer contributes to the Plan, and if so, the contributing Employer's address.

ELIGIBILITY AND PARTICIPATION

Eligibility

To determine whether you, your legal spouse, and/or your children under age 26 are eligible for coverage with respect to any benefit option under the Plan, please read the information contained in the Booklets issued by the insurer or the Company, as applicable, for that benefit option.

The employees eligible to participate in the pre-tax health care premium option, the Health Savings Account, the Health Care Flexible Spending Account or Limited Health Care Flexible Spending Account, and the Dependent Care Spending Account are listed on Appendix B.

Termination of Participation

Except as otherwise required by applicable law or as stated in a Booklet (or pursuant to a written agreement with your Employer), your eligibility for Plan benefits terminates when your employment terminates with your Employer. Coverage may also terminate if you fail to pay your share of any premium, if you no longer satisfy the eligibility requirements, if you submit false claims, etc. (See the Booklets for the applicable benefit option for more information.) Coverage for your legal spouse and dependents stops when your coverage stops. Their coverage may also cease for other reasons (such as divorce, dependent attains age limit, dependent gets married, etc.), as specified in the applicable Booklets. Eligibility for a particular benefit will also cease if your Employer stops providing that benefit or the Company terminates the Plan.

Rescission of Coverage

A rescission of your coverage means that the coverage may be legally voided all the way back to the day the Plan began to provide you with coverage, just as if you never had coverage under the Plan. Your coverage can only be rescinded if you (or a person seeking coverage on your behalf), performs an act, practice, or omission that constitutes fraud; or unless you (or a person seeking coverage on your behalf) makes an intentional misrepresentation of material fact. You will be provided with thirty 30 days' advance notice before your coverage is rescinded. You have the right to request an internal appeal of a rescission of your coverage. Once the internal appeal process is exhausted, you have the additional right to request an independent external review. If your coverage is rescinded, you will be required to repay any benefits that you have received.

Application and Enrollment in Benefit Plans

You are eligible to become enrolled in benefits on your earliest effective date, subject to any additional requirements imposed by an insurer as described in the applicable Booklet. Your earliest effective date is 30 days from your date of hire or entry into an eligible employment classification.

You will be automatically enrolled in the following benefit plans on your earliest effective date:

- Basic Group Term Life and AD&D Insurance
- Long Term Disability Insurance
- Business Travel Accident Insurance

You are required to make application for and, if applicable, supply dependent documentation in order to become enrolled in the following benefit plans:

- Health and Dental

- Flexible Spending Accounts (Health Care or Dependent Care)

Your complete application (including dependent documentation, if applicable) must be submitted no later than 30 days after your earliest effective date. Your earliest effective date is 30 days from your date of hire or entry into an eligible employment classification. This is known as the 30 day waiting period. Employees who change employment classification (e.g., full-time to covered part-time or covered part-time to full-time) will not be required to re-satisfy the 30 day waiting period. Their earliest effective date will be the date their employment classification changed. You will become enrolled on the later of your earliest effective date or the date you submit a complete application for benefits (with required dependent documentation, if applicable) as long as the application is received no later than 30 days after your earliest effective date. In the event you do not submit a complete application for benefits within the time frame specified above, you will be ineligible to enroll until the next annual open enrollment period, unless you experience a Qualified Life Event (QLE) as defined by the Internal Revenue Service (IRS).

You may apply for coverage under the Optional Group Term Life Insurance Plan for yourself, your legal spouse and/or your children at any time during the year.

Annual Open Enrollment Period
You may change plan options, coverage levels and covered dependents only during the annual open enrollment period. The annual open enrollment period will be held during the last quarter of each calendar year. Changes made during the annual open enrollment period become effective on the first day of the following calendar year (January 1). Employees are required to re-enroll in Flexible Spending Accounts (FSAs) each year.

Qualified Life Events
The decision to participate generally will be binding for the full Plan year. Outside of the annual open enrollment period, employees may only make changes if they experience a Qualified Life Event as defined by the Internal Revenue Service (IRS). Qualified Life Events include:

A Qualified Life Event means:

- Events that change your legal marital status, including marriage, death of spouse, divorce, legal separation, and annulment.

- Events that change your number of dependents, including birth, death, adoption, and placement for adoption. (Note: Gaining or losing a dependent such as a parent will not be considered an allowable event for an election change, unless such person is a dependent under Section 152 of the Code).

- Events that change your employment status or the employment status of your spouse or dependents that effect your eligibility for benefits including a termination or commencement of employment, a strike or lockout, a commencement of or return from an unpaid leave of absence or a change in worksite.

- Events that cause your dependent to satisfy or cease to satisfy eligibility requirements for coverage on account of attainment of age, student status, or any similar circumstances.

- Events that allow a HIPAA "special enrollee" to enroll or change his or her existing Plan option in the Plan after: a loss of eligibility for group health coverage, health insurance coverage, SCHIP, or Medicaid; or becoming eligible for state premium assistance, Medicaid or SCHIP subsidies.

- A significant change in benefits cost or coverage.

- A change in your place of residence, the place of residence of your spouse or dependent that affect eligibility for benefits under the Plan.

- A coverage change of another employer plan. You may change your election under the Plan if the change is on account of and consistent with a change in another employer's plan and (i) the change is permitted under the cafeteria plan of the other employer or (ii) the periods of coverage under the Plan are different from the periods of coverage under the plan of the other employer.

- For the Dependent Care Flexible Spending Account only, a change in the cost of dependent care imposed by the provider. You may make a new election for the remainder of the year if a cost change is imposed during the year by a dependent care provider who is not your relative (as relative is defined in Section 152(a)(1)-(8) of the Code), provided the increase or decrease of your election is consistent with the change in cost.

- For the Dependent Care Flexible Spending Account only, a change in dependent care provider. You may make a new election for the availability of dependent care services from the new child care provider (regardless of whether the new provider is a household employee or your family member).

An election change is consistent with a Qualified Life Event only if it is on account of and corresponds with the Qualified Life Event (e.g. increase coverage level for birth or marriage).

To make an election change because of a Qualified Life Event, you must notify the Plan Administrator and submit the election change within 60 days of the Qualified Life Event. You may not make a mid-year election change more than 60 days after the Qualified Life Event.

Overpayments
If you receive an erroneous payment or payment amount, you must repay the Plan the amount of the error. The Plan may reduce future Benefits payable to you or on your behalf by the amount of the error. In addition, if you receive a benefit as a result of false or incomplete information or a misleading or fraudulent representation, you must repay all amounts to the Plan and you will be liable for all collection costs including attorneys' fees and court costs.

Summary of Plan Benefits
The Plan provides eligible employees and their dependents with certain welfare and health insurance benefit options. Some of these benefit options are provided under a group insurance

contract entered into between the Company and an insurer. Other benefit options are provided on a self-funded basis and paid out of the general assets of the Company. The terms of the benefit options provided under the Plan are summarized in the Booklets issued by the insurer and/or the Company, as applicable.

PRE-TAX PREMIUM PAYMENT AND FLEXIBLE SPENDING ACCOUNTS

Below is an example of how you may be able to increase your take-home pay by electing to participate in the pre-tax premium payment option and/or the Flexible Spending Accounts.

By entering into a Salary Reduction Agreement, your benefit costs are reduced as illustrated by the following example:

	With the Plan	Without the Plan
Gross Taxable Wages	$25,000.00	$25,000.00
Pre-tax Contribution	1,800.00	N/A
Taxable Wages	$23,200.00	$25,000.00
Estimated Taxes*	3,480.00	3,750.00
After-tax Contribution	N/A	1,850.00
Take-home Pay	$19,720.00	$19,450.00

*Joint Return, 15% marginal tax rate

By paying for benefits before taxes are calculated, estimated taxes are reduced by $270, which is $22.50 per month more in take-home pay for this example person. In other words, paying for benefits without entering into a Salary Reduction Agreement would cost this person $22.50 more per month. You should consult a tax advisor for a more accurate estimate for your situation.

Pre-Tax Premium Payments
By paying your share of the premiums for your elected benefits as a reduction to your compensation under a Salary Reduction Agreement, your contribution will not be subject to federal income tax, Social Security tax, and in most cases state income tax, and can result in a net increase in spendable income. The Employers pay their portion of the costs for your elected benefits, if any, out of their general assets.

Health Care Flexible Spending Account and Limited Purpose Flexible Spending Account
You may elect the Health Care Flexible Spending Account if you do not elect the high-deductible health coverage and Health Savings Account options.

You may elect the Limited Purpose Health Care Flexible Spending Account if you elect high-deductible health coverage and Health Savings Account options.

Health Care Flexible Spending Account

The Health Care Flexible Spending Account will reimburse you for any qualified medical expenses that are not covered by medical insurance or any other benefit program, up to the annual amount that you elected to reduce your compensation and have contributed to the Health Care Flexible Spending Account. The maximum annual amount that you may reduce your compensation for contributions to the Health Care Flexible Spending Account is $2,500. This amount may be adjusted under the Internal Revenue Code for changes in the cost of living.

The Health Care Flexible Spending Account generally reimburses expenses that are for "medical care," as defined in Section 213(d) of the Code, as modified by Section 106(f) of the Code, and

which are not covered by health insurance or another benefit arrangement. Typical expenses include medically necessary vision, dental and medical expenses, office visit co-pays, prescription co-pays, prescribed over-the-counter (OTC) drugs and medications, insulin and diabetic testing supplies, and other OTC items permitted under Section 213(d) of the Code as modified by Section 106(f) of the Code. Expenses solely for cosmetic or well-being reasons are not expenses for medical care.

Limited Purpose Health Care Flexible Spending Account

The Limited Purpose Health Care Flexible Spending Account will reimburse you for any qualified dental and vision expenses that are not covered by medical insurance or any other benefit program, up to the annual amount that you elected to reduce your compensation and have contributed to the Limited Purpose Health Care Flexible Spending Account. The maximum annual amount that you may reduce your compensation for contributions to the Limited Purpose Health Care Flexible Spending Account is $2,500. This amount may be adjusted under the Internal Revenue Code for changes in the cost of living.

Reimbursements

The Health Care Flexible Spending Account or Limited Health Care Flexible Spending Account will reimburse you for claims for a qualified benefit you incur while a Participant, up to the maximum you elected, at any time during the Plan year. For example, assume that you have elected to contribute $1200 for the Plan year, $100 each month. During the first month when there is only $100 in your account, you have qualified medical expenses of $300. The Health Care Flexible Spending Account or Limited Purpose Flexible Spending Account must reimburse you the full $300 and take the risk that you might terminate employment before the full $300 has been contributed.

Changes

Once you have entered into a Salary Reduction Agreement for contributions to the Health Care Flexible Spending Account or Limited Health Care Flexible Spending Account, you cannot change that election, subject to the exception regarding a Qualified Life Event. The Third Party Administrator will finish the accounting for the plan year 120 days after the last day of the Plan year. You must submit any remaining claims for reimbursement before that date.

No Carryover

Should you fail to spend all the money you defer to the Health Care Flexible Spending Account or Limited Purpose Health Care Flexible Spending Account for a Plan year within 2 ½ months after the end of that Plan year (that is, March 15), you cannot carry that money over. Any money left over after the March 15 following the end of the Plan year becomes the property of the Employer. It is, therefore, very important that you determine as accurately as possible how much you wish to defer to the Health Care Flexible Spending Account or Limited Health Care Flexible Spending Account.

Filing Claims for Reimbursement

A qualified medical expense can only be reimbursed under your Health Care Flexible Spending Account or Limited Health Care Flexible Spending Account when a claim is submitted to the Third Party Administrator in the manner required by the Third Party Administrator. Your claims must include a written statement from your medical provider that a medical expense has been incurred and the amount of the expense, and a written statement from you that the medical expense has not been reimbursed and is not reimbursable under any other health plan coverage.

The Third Party Administrator will determine whether the claim is covered within 30 days of receipt of the claim for reimbursement. In addition to the items described above, the Plan Administrator will require proper evidence of the following:

(1) the name of the person or persons for whom the expenses have been incurred;

(2) the nature of the expenses incurred;

(3) the date the expenses were incurred; and

(4) the amount of the requested reimbursement.

Each claim for benefits must be accompanied by a third party statement that substantiates these required items. If the Third Party Administrator permits claims to be submitted electronically, you will be required to sign a certification upon enrollment or acceptance of an electronic card that among other things certifies that claims submitted under the card have not been reimbursed or are not reimbursable under any other health plan coverage.

Dependent Care Flexible Spending Account

To be eligible to contribute to your Dependent Care Flexible Spending Account and to be reimbursed for your dependent care expenses, you must satisfy the requirements summarized below:

Work Requirements:

- Your dependent care expenses must be incurred to allow you (and your spouse if you are married) to provide care for a "qualifying individual" while you and your spouse work or look for work. Therefore, a married employee whose spouse is not employed cannot participate in the Plan (but see "Student Spouses and Disabled Spouses" below).

- "Work" includes actively looking for paid employment, but you must have earned income by the end of the year.

- Unpaid volunteer work or volunteer work for a nominal salary does not qualify.

Dependent Care Expenses:

- Dependent Care Expenses must be for the well-being and protection of a qualifying individual. You must pay these expenses to care for one or more qualifying individuals or for household services for a qualifying individual.

- Expenses you pay for ordinary services done in and around your home that are necessary to run your home will qualify provided that they are at least partly for the well-being and protection of a qualifying individual. Household services do not include expenses for a qualifying individual's food, clothing, education, or entertainment.

- Dependent care expenses include the cost of care outside your home if the care is for a child or other qualifying individual who regularly spends at least eight hours each day in your household.

- Reimbursement of dependent care expenses for care outside your home is subject to more restrictive rules if the care is provided at a dependent care center. In this case, your expenses qualify as dependent care expenses only if the care center complies with all applicable state and local regulations. A dependent care center is any person or organization which provides care for more than six persons (other than persons who live there) and receives a fee for providing services to any of those individuals.

- The cost of getting a qualifying individual to and from your home and the care location is not an eligible expense.

- You cannot be reimbursed for dependent care expenses paid to someone you or your spouse can claim as a dependent and, if the person you made payments to was your child, he or she must have been age 19 or older by the end of the year.

- Dependent care expenses must be incurred during the Plan Year in order to be reimbursed. Dependent care expenses will be deemed to have been incurred during that time if the care services leading to the expenses were performed during that time.

Qualifying Individuals:

- A qualifying individual is:

  - Your dependent under age 13 (but see "Child Of Divorced Or Separated Parents" below), or

  - Your dependent (or a person you could claim as a dependent except that the person has gross income of $2,000 or more) who is physically or mentally unable to care for himself or herself, or

  - Your spouse who is physically or mentally incapable of caring for himself or herself.

Child Of Divorced
Or Separated Parents:

- If you are divorced or separated, your child is a qualifying individual if:
  - You are the custodial parent, and your child:
    -- was under age 13 or was not able to care for himself or herself,
    -- was in the custody of one or both parents for more than half of the year, and
    -- received more than half of his or her support from one or both parents, and
  - You claim your child as your dependent on your tax return, or you agreed to allow the non-custodial parent to claim the dependency exemption.

Reimbursement Limit:

- You may request reimbursement for dependent care expenses up to $5,000 per year ($2,500 if you are married and file a separate return).
- However, your maximum reimbursement during a calendar year may not be more than:
  - Your earned income (generally your salary) for the year, if you are single at the end of the calendar year, or
  - The smaller of your earned income or your spouse's earned income for the year, if you are married at the end of the calendar year. (See "Student Spouse or Disabled Spouse" below.)

Student Spouse
Or Disabled Spouse:

- If you are married and, for any month, your spouse is either a full-time student or unable to care for himself or herself, your spouse will be considered to have earned income of $250 a month if there is one qualifying individual in your home, or $500 a month if there are two or more qualifying individuals in your home.
- A full-time student is one who is enrolled at a school during each of 5 calendar months of the calendar year, not necessarily consecutive, for the number of hours considered to be a full-time course of study.

Once you have entered into a Salary Reduction Agreement for contributions to the Dependent Care Flexible Spending Account, you cannot change that election, subject to the exception regarding a Qualifying Life Event. The Third Party Administrator will finish the accounting for the Plan year 120 days after the March 15 following the Plan year. You must submit any remaining claims for reimbursement before that date.

Should you fail to spend all the money you defer to the Dependent Care Flexible Spending Account for a Plan year within 2 ½ months after the end of that Plan year (that is, March 15), you cannot carry that money over. Any money left over after the March 15 following the end of the Plan year becomes the property of the Employer. It is, therefore, very important that you determine as accurately as possible how much you wish to defer to the Dependent Care Flexible Spending Account.

A dependent care expense can only be reimbursed under your Dependent Care Flexible Spending Account when a claim is submitted to the Third Party Administrator in the manner and with the substantiation required by the Third Party Administrator.

Time Limits for Filing Claims
Claims for reimbursement from amounts deferred under the Flexible Spending Accounts for a Plan Year must be filed within 120 days after the March 15 following the end of the Plan year. For an employee whose employment terminates during a Plan year, claims for reimbursement must be filed within 120 days of the employee's termination date.

HEALTH SAVINGS ACCOUNT

Establishing a Health Savings Account ("HSA")

A Health Savings Account ("HSA") is a trust or custodial account established with a custodian or trustee to be used for reimbursement of "eligible medical expenses" incurred by you or your eligible tax dependents. The HSA is administered by the HSA custodian or trustee or its designee subject to the terms and conditions of the agreement between you and the custodian or trustee. The HSA is not an employee benefit plan sponsored or maintained by the Employers. Your Employer's role with respect to the HSA is limited to making contributions through the STERIS Corporation Flexible Benefits Plan to the HSA established by you with the custodian or trustee (through pre-tax salary reductions elected by you and/or Employer contributions). The Employer has no authority or control over the funds deposited in your HSA. As such, an HSA offered through the STERIS Corporation Flexible Benefits Plan is not subject to the Employee Retirement Income Security Act of 1974 (ERISA).

IRS Eligibility Requirements

Eligibility to establish and contribute to an HSA is determined under IRS rules and the applicable terms and conditions of the custodial or trust agreement. You are eligible for contributions to your HSA during any month if you satisfy the following conditions on the first day of that month:

(a) You are covered under a qualifying high deductible health plan maintained by your Employer;

(b) You must not be:

(i) covered under any other health plan or program that is not a qualifying high deductible health plan unless that coverage is limited to "permitted coverage," "permitted insurance" and/or preventive care as defined in Code Section 223 and related guidance;

(ii) entitled to Medicare; or

(iii) eligible to be claimed as a dependent of any other taxpayer.

You are required to notify your Employer if you fail to satisfy these conditions on the first day of any month following the date that you first certify that you meet these requirements.

(c) You are otherwise eligible to participate in the STERIS Corporation Flexible Benefits Plan.

(d) Your spouse is not covered by a health care flexible spending account or health reimbursement arrangement that could pay for any of your medical expenses before you meet the deductible under your Employer's high deductible health plan.

Contributions to Your HSA

Contributions may consist of pre-tax contributions made by you pursuant to a salary reduction agreement and/or Employer contributions made through the STERIS Corporation Flexible Benefits Plan. Contributions to your HSA could also be made by you on an after-tax basis from a personal checking account.

The maximum annual contribution to your HSA for 2015 cannot exceed the following amounts:

- $3,350 for self-only coverage ($2,850 after your Employer's $500 contribution)
- $6,650 for self-only plus spouse coverage ($5,650 after your Employer's $500 contribution)
- $6,650 for self plus family coverage $5,650 after your Employer's $1,000 contribution)
- During the year in which you become age 55 and following years, a catch-up contribution of up to $1,000 is permitted

Further Information

For further details concerning your rights and responsibilities with respect to your HSA (including information about the terms of eligibility, your Employer's qualifying high deductible health plan, contributions to the HSA, and distributions from the HSA), please refer to your HSA custodial agreement and the HSA communication materials provided to you by your Employer.

LEGAL REQUIREMENTS

The Plan will provide benefits in accordance with the applicable requirements of various Federal laws, including, without limitation: COBRA, the Health Insurance Portability and Accountability Act of 1996, as amended ("HIPAA"), the Health Information Technology for Economic and Clinical Health Act ("HITECH"), the Newborns' and Mothers' Health Protection Act of 1996 ("NMHPA"), and the Women's Health and Cancer Rights Act of 1998 "WHCRA").

These laws are summarized below (but will be applied in accordance with the rules specified in the Booklets, if any):

COBRA
Federal law requires that the Plan extend health coverage, at your expense, in certain instances where coverage under the group health plan would otherwise end. For example, if coverage for you, your legal spouse or dependents ceases because of certain "qualifying events" (e.g., termination of employment, reduction in hours, divorce, death, child ceasing to meet the Plan's definition of dependent) specified in a federal law known as the Consolidated Omnibus Budget Reconciliation Act of 1985, as amended ("COBRA"), then you, your legal spouse or your dependents may have the right to purchase COBRA continuation coverage under the Plan for a limited period of time. If required, you will be offered COBRA coverage for the period of time required by law (generally 18 months, but 36 months in some circumstances) and you will be charged the maximum premiums allowed. For more information about your right to COBRA continuation coverage, please refer to the applicable Booklet with respect to a particular benefit option, or contact the Plan Administrator.

If you elect to participate under the Health Care Flexible Spending Account and are considered a participant on the day before experiencing a qualifying event – termination of employment or reduction in hours – you are only eligible to continue the Health Care Flexible Spending Account under COBRA until the end of the current Plan year. You will be charged the maximum premium amount allowed. If on the day of your qualifying event, the amount of your annual election less any claims that have been reimbursed is less than the amount of premium required to continue the Health Care Flexible Spending Account until the end of the Plan year, then COBRA continuation coverage will not be offered.

Qualified Medical Child Support Orders
This Plan will also extend group health plan benefits to an employee's non-custodial child, as required by any qualified medical child support order ("QMCSO"), as defined in ERISA Section 609(a). The Plan has detailed procedures for determining whether an order qualifies as a QMSCO. Participants and beneficiaries can obtain, without charge, a copy of the procedures from the Plan Administrator.

Benefits for Adopted Children
The Plan also will extend benefits to dependent children placed for adoption with participants or beneficiaries under the same terms and conditions as apply in the case of dependent children who are the natural children of participants or beneficiaries.

Maternity or Newborn Infant Coverage
Group health plans and health insurance issuers generally may not, under Federal law, restrict benefits for any hospital length of stay in connection with childbirth for the mother of a newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. However, Federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). In any case, plans and issuers may not, under Federal law, require that a provider obtain authorization from the plan or the issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours).

Women's Health and Cancer Rights Act
As required by the WHCRA, the Plan provides benefits for mastectomy-related services including (i) reconstruction of the breast on which a mastectomy has been performed, (ii) surgery and reconstruction of the other breast to produce a symmetrical appearance, (iii) prostheses and (iv) treatment of physical complications of all stages of mastectomy, including lymphedemas. Please contact the Plan Administrator for more information.

Mental Health Parity Act
Group health plans and health insurance issuers are required to provide parity between medical/surgical benefits and mental health benefits in the application of annual dollar limits and aggregate dollar limits. Under current law, group health plans with annual or lifetime dollar limits for medical/surgical benefits must apply the same or higher dollar limits for mental health benefits.

Family and Medical Leave Act of 1993 ("FMLA")
If you are eligible for a leave of absence under FMLA, you may continue to participate and receive benefits under the Plan in accordance with FMLA rules and regulations. Essentially, you and your Employer are responsible for making the same portion of premium payments that you and your Employer were making before your leave of absence. In the event that you take a leave of absence under FMLA, the Plan Administrator will explain the options available to you for making your portion of any premium payments. You may also be permitted to revoke certain elections during your leave and elect reinstatement under the same terms as your prior election upon returning to work. Please contact the Plan Administrator for more information.

Leave for Duty with the Uniformed Services
If you are eligible for a leave of absence for active military duty, you may continue to participate and receive certain benefits in accordance with the Uniformed Services Employment and Reemployment Rights Act of 1994 ("USERRA"). If you are absent from work due to a period of active duty in the military for less than 31 days, your participation under the Plan will not be interrupted. In the event that you take a leave of absence for active military duty, the Plan Administrator will explain the options available to you for making your portion of any premium payments. Please contact the Plan Administrator for more information.

HIPAA and HITECH Privacy Rules
The Plan is required to meet the privacy requirements of HIPAA and HITECH. In accordance with these rules, the Plan, the Company, and any insurer will not use or disclose health information protected by HIPAA except when such use or disclosure is necessary for treatment, payment, Plan operations, or as permitted or required by other state and Federal law. Each of the business associates of the Plan are also required to observe HIPAA's privacy rules. In addition, neither the Plan nor the Company will use or disclose protected health information for employment-related actions and decisions (or in connection with any other employee benefit plan of the Company) without express written authorization from you. In the unlikely event that an unauthorized disclosure of your protected health information occurs, you will be notified.

You should have received a detailed Notice of Privacy Practices from the Insurer (for fully insured benefit options) or from a Third Party Administrator or the Company (for self-insured benefit options). If you have not received a copy, please contact the Plan Administrator.

If you believe your rights under HIPAA have been violated, you have the right to file a complaint with the Plan or with the Secretary of the U.S. Department of Health and Human Services. If you wish to file a HIPAA complaint with the Plan, please contact the Company's HIPAA Privacy Officer. With respect to any fully insured benefit option, you may also request HIPAA privacy information directly from an Insurer. Contact information for the insurer of a fully insured benefit option is provided in the applicable Booklet. Contact information for a Third Party Administrator is provided in the applicable Booklet. Contact information for the Company is provided on page 2 of this summary.

Medicaid and the Children's Health Insurance Program (CHIP)
Offer Free or Low-Cost Health Coverage to Children and Families
If you are eligible for health coverage from your employer, but are unable to afford the premiums, some States have premium assistance programs that can help pay for coverage. These States use funds from their Medicaid or CHIP programs to help people who are eligible for employer-sponsored health coverage, but need assistance in paying their health premiums.

If you or your dependents are already enrolled in Medicaid or CHIP, you can contact your State Medicaid or CHIP office to find out if premium assistance is available.

If you or your dependents are NOT currently enrolled in Medicaid or CHIP, and you think you or any of your dependents might be eligible for either of these programs, you can contact your State Medicaid or CHIP office or dial 1-877-KIDS NOW or www.insurekidsnow.gov to find out how to apply. If you qualify, you can ask the State if it has a program that might help you pay the premiums for an employer-sponsored plan.

Once it is determined that you or your dependents are eligible for premium assistance under Medicaid or CHIP, your employer's health plan is required to permit you and your dependents to enroll in the plan – as long as you and your dependents are eligible, but not already enrolled in the employer's plan. This is called a "special enrollment" opportunity, and you must request coverage within 60 days of being determined eligible for premium assistance.

In some States, you may be eligible for assistance paying your employer health plan premiums. You should contact your State for further information on eligibility. You may contact the STERIS benefits department for an updated list of State contacts.

HOW THE PLAN IS ADMINISTERED

Plan Administration
The Plan Administrator of the Plan is the Company. The Plan Administrator has the discretion to interpret the terms and the purpose of the Plan and its decisions are conclusive and binding (subject to the applicable claims and appeals procedures specified below or in the Booklets).

Plan Expenses
The incidental costs of administering the Plan will be paid by the Plan, unless the Company elects to pay some or all of the costs directly.

Time Limits for Filing Claims

Only those claims for benefits that are timely filed will be paid under the Plan. Except to the extent specifically provided otherwise in the Booklets, a claim for benefits must be filed no later than 36 months after the date on which the claim was incurred.

CLAIMS PROCEDURE

A claim for benefits under a fully insured benefit option will be reviewed in accordance with claims procedures established by the applicable insurer and generally described in the applicable Booklet provided by the insurer. A claim for benefits under a self-insured benefit option will be reviewed in accordance with claims procedures established by the Third Party Administrator specified in the Booklet for the benefit option.

Only in the event that the Booklet for a particular benefit option does not specify the manner in which claims are to be made, the following claims procedures will apply:

If you have a claim for benefits under a benefit option that does not specify how to make a claim for benefits, you must file the claim with the Plan Administrator, in the manner prescribed by the Plan Administrator, along with any relevant information or documentation that the Plan Administrator considers necessary and reasonable under the circumstances. Initial claims will be processed within the following periods of time:

Urgent Care Claims

- **Initial Claim Review:**
  The claim must be decided as soon as possible, but no later than 72 hours after the claim is received by the Plan Administrator.

- **If the Proper Claims Procedure Was Not Followed:**
  The Plan Administrator must notify you within 24 hours of the failure to follow the proper procedure and provide the procedure to follow.

- **If Additional Information is Needed:**
  If the Plan Administrator cannot render a decision because of incomplete information, the Plan Administrator must notify you within 24 hours of the specific information required to complete the claim. You will then have 48 hours to provide the requested information. The Plan Administrator will render a final decision 48 hours after the earlier of receipt of the information from you or the expiration of the 48 hours you were given to provide the requested information.

- **Appeal:**
  You have 180 days following receipt of written notice that a claim was either denied or reduced in which to file an appeal. You or your representative may examine the Plan and additional documents relevant to your claim and may submit issues and comments in writing, or a request for an expedited appeal may be submitted orally or in writing. All necessary information, including the Plan Administrator's benefit determination on review, will be transmitted by the Plan Administrator by telephone, facsimile, or other available similarly expeditious method. The Plan Administrator must render a decision on the appeal as soon as possible, but no later than 72 hours after receiving your written request for appeal. If you do not file a request for review of the claim within the 180 day period, it will be conclusively presumed by the Plan Administrator that you have accepted as final and binding the initial decision of the Plan Administrator.

Pre-Service Claims

- **Initial Claim Review:**
  The claim must be decided within 15 days after the claim is received by the Plan Administrator. The Plan Administrator may extend the review period an additional 15 days if necessary due to circumstances beyond the Plan Administrator's control. If this is the case, the Plan Administrator must notify you within the initial 15 day period of the extension and provide you with the reason for the extension and the date you can expect a decision.

- **If the Proper Claims Procedure Was Not Followed:**
  The Plan Administrator must notify you within 5 days of failure to follow the proper procedure and provide the procedure to follow.

- **If Additional Information is Needed:**
  If the Plan Administrator cannot render a decision because of incomplete information, the Plan Administrator must notify you of the specific information required to complete the claim within 15 days of the date the claim was filed. You will then have 45 days to provide the requested information. The Plan Administrator has 15 days from the date it receives the requested information to render a final decision.

- **Appeal:**
  You have 180 days following receipt of written notification that a claim was denied in which to file an appeal. You or your representative may examine the Plan and additional documents relevant to your claim and may submit issues and comments in writing. A decision on the appeal must be made by the Plan Administrator within 30 days of receiving the request for review or appeal.

Concurrent Care Claims

- **Initial Claim Review:**
  When notifying you of a reduction or termination of benefits for a previously approved and ongoing treatment plan, the Plan Administrator must provide you with enough advance notice to appeal the decision prior to the reduction or termination of benefits. If the patient is receiving urgent care, you may request an extension of the course of treatment, provided your request is made at least 24 hours before benefits would end. Your request for an extension to an urgent care course of treatment must be decided upon as soon as possible, but no later than 24 hours after the request is received by the Plan Administrator.

- **Appeal:**
  You have 180 days following receipt of written notice that a claim was either denied or reduced in which to file an appeal. After a request for review or appeal is received, the Plan Administrator must make a decision within (a) 72 hours for urgent care claims; (b) 30 days for pre-service claims; and (c) 60 days for post-service claims.

Post-Service Claims

- **Initial Claim Review:**
  The claim must be decided within 30 days after the claim is received by the Plan Administrator. The Plan Administrator may extend the review period an additional 15 days if necessary due to circumstances beyond the Plan Administrator's control. If this is the case, the Plan Administrator must notify you within the initial 30 day period of the extension and provide you with the reason for the extension and the date a decision can be expected.

- **If the Proper Claims Procedure Was Not Followed:**
  The Plan Administrator must notify you within 5 days of failure to follow the proper procedure and provide the procedure to follow.

- **If Additional Information is Needed:**
  If the Plan Administrator cannot render a decision because of incomplete information, the Plan Administrator must notify you within 30 days of the date the claim was filed of the specific information required to complete the claim. You will then have 45 days to provide the requested information. The Plan Administrator has 30 days from the date it receives the requested information to render a final decision.

- **Appeal:**
  You have 180 days following receipt of written notice that a claim was denied in which to file an appeal. You or your representative may examine the Plan and additional documents relevant to your claim and may submit issues and comments in writing. A decision on the appeal must be made by the Plan Administrator within 60 days of receiving the request for review or appeal.

Disability Claims

- **Initial Claim Review:**
  The claim must be decided within 45 days after the claim is received by the Plan Administrator. The Plan Administrator may extend the review period an additional 30 days if necessary due to circumstances beyond the Plan Administrator's control. If this is the case, the Plan Administrator must notify you within the initial 45 day period of the extension and provide you with the reason for the extension and the date a decision can be expected. If prior to the end of the 30 day extension period, the Plan Administrator determines that, due to matters beyond control of the Plan Administrator, a decision cannot be rendered within that extension period, the period for making the determination may be extended for up to an additional 30 days. If this is the case, the Plan Administrator must notify you within the 30 day extension period of the reason for the additional extension and the date a decision can be expected. If such extensions are necessary, the notice of the extension shall specifically explain the standards on which entitlement to a benefit is based, the unresolved issues that prevent a decision on the claim, and the additional information needed to resolve those issues. You will be afforded at least 45 days within which to provide the specified information.

- **If the Proper Claims Procedure Was Not Followed:**
  The Plan Administrator must notify you within 5 days of failure to follow the proper procedure and provide the procedure to follow.

- **If Additional Information is Needed:**
  If the Plan Administrator cannot render a decision because of incomplete information, the Plan Administrator must notify you within 45 days of the date the claim was filed of the specific information required to complete the claim. You will then have 45 days to provide the requested information. The Plan Administrator has 30 days from the date it receives the requested information to render a final decision.

- **Appeal:**
  You have 180 days following receipt of written notice that a claim was denied in which to file an appeal. You or your representative may examine the Plan and additional documents relevant to your claim and may submit issues and comments in writing. If you do not file such a request for review of the claim within such 180 day period, it will be conclusively presumed by the Plan Administrator that you have accepted as final and binding the initial decision of the Plan Administrator. A decision on the appeal must be made by the Plan Administrator within 45 days of receiving the request for review or appeal.

Other Claims

- **Initial Claim Review:**
  The claim must be decided within 90 days after the claim is received by the Plan Administrator. The Plan may extend the review period an additional 90 days if necessary due to circumstances beyond the Plan Administrator's control. If this is the case, the Plan Administrator must notify you within the initial 90 day period of the extension and provide you with the reason for the extension and the date a decision can be expected.

- **If the Proper Claims Procedure Was Not Followed:**
  The Plan Administrator must notify you within 5 days of failure to follow the proper procedure and provide the procedure to follow.

- **If Additional Information is Needed:**
  If the Plan Administrator cannot render a decision because of incomplete information, the Plan Administrator must notify you within 30 days of the date the claim was filed of the specific information required to complete the claim. You will then have 45 days to provide the requested information. The Plan Administrator has 30 days from the date it receives the requested information to render a final decision.

- **Appeal:**
  You have 60 days following receipt of written notice that a claim was denied in which to file an appeal. A decision on the appeal must be made by the Plan Administrator within 60 days of receiving the request for review or appeal.

Notice of Adverse Benefit Determination

If you file a claim for benefits and your claim is denied in whole or in part, you will receive a written notice of adverse benefit determination. The notice will:

(1) state the specific reasons for the adverse decision;

(2) (i) include information sufficient to identify the claim involved (including the date of service, the health care provider, the claim amount (if applicable), and a statement describing the availability, upon request, of the diagnosis code and its corresponding meaning, and the treatment code and its corresponding meaning; (ii) include a description of the internal appeal and external appeal procedures; and (iii) disclose the availability of, and contact information for, any applicable office health insurance consumer assistance or ombudsman established to assist individuals with the internal claims and appeals and external review processes;

(3) make specific references(s) to pertinent provisions of the Plan on which the decision is based;

(4) notify you that you are entitled to receive upon request and free of charge, reasonable access to, and copies of, all documents, records and other information relevant to your claim for benefits

(5) include a statement of your right to bring an action under ERISA Section 502;

(6) notify you if any internal rule, guideline, protocol, or other similar criterion was relied on in making the adverse determination, and specify that a copy of the rule, guideline, protocol, or other similar criterion will be provided free of charge upon request;

(7) include a statement that you and the Plan may have other voluntary alternative dispute resolutions options, such as mediation. One way to find out what may be available is to contact your local U.S. Department of Labor Office and your State insurance regulatory agency;

(8) in the case of an adverse benefit determination that is based on a medical necessity or experimental treatment or similar exclusion or limit, specify that you may request free of charge an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to the your medical circumstances; and

(9) specify that to the extent permitted by applicable law, the adverse decision will be final and binding on all interested persons, except in the case of a benefit option that is a group health plan where you may request an external review.

During the appeal process, you may retain legal counsel. Your authorized representative or beneficiary may send a request on your behalf. You, or your representative, are permitted to inspect relevant Plan documents which may affect your claim. You may keep copies of all documents for your own records.

Once a final decision is made, the Plan Administrator will provide you with a written notice. The notice will include the specific reasons for the decision and references to the Plan provisions on which the decision was based. If you do not receive a written response within the aforementioned time period (or any applicable extension period), you may consider the appeal denied.

If you receive a notice of final adverse benefit determination for a benefit option that is a group health plan, you may request an external review. The Booklet for the benefit option will describe how you may request an external review. You may also request further information from the Plan Administrator.

The above claims procedure is outlined in Section 503 of ERISA and applies to all plans covered under Title I of ERISA. If you do not request a review for a denied claim in accordance with these procedures, you will have no right of review, and no right to bring an action in any court.

A claim is considered filed on the date it is filed in accordance with reasonable procedures of the Plan Administrator, not the date all necessary information has been received by the Plan Administrator. However, the Plan Administrator may apply an extension if additional information is necessary for proper assessment of a claim.

Naturally, both you and the Company will want to avoid legal action. But if you feel legal action is necessary, any summons or legal documents should be served on the Agent for Service of Legal Process (See *Important Facts* above).

DISQUALIFICATION, INELIGIBILITY, DENIAL, OR LOSS OF BENEFITS

The following is a list of some of the events that may result in your disqualification, ineligibility, denial or loss of benefits under the Plan:

- A change in your employment status may cause you to become ineligible to continue coverage under one or more benefit options.
- You will lose coverage under a benefit option if you do not pay any required participant contributions.
- Amendments to the Plan may result in curtailment or cessation of existing Plan benefits, or result in other changes to the Plan's provisions.
- Termination of the entire Plan by the Company would result in no further benefits under the Plan and no further participation in the Plan.

If you have any questions about a circumstance that you believe may affect your Plan participation or right to receive benefits, you should contact the Plan Administrator.

STATEMENT OF ERISA RIGHTS

As a participant in the Plan, you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA). ERISA provides all Plan participants will be entitled to:

Receive Information About Your Plan and Benefits

- Examine, without charge, at the Plan Administrator's office and at other specified locations, such as worksites, all documents governing the Plan, including insurance contracts and collective bargaining agreements, and a copy of the latest annual report (Form 5500 Series) filed by the Plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration.

- Obtain, upon written request to the Plan Administrator, copies of all documents governing the operation of the Plan, including insurance contracts and collective bargaining agreements, and copies of the latest annual report (Form 5500 Series) and updated summary plan descriptions. The Plan Administrator may make a reasonable charge for the copies.

- Receive a summary of the Plan's annual financial report. The Plan Administrator is required by law to furnish each participant with a copy of this summary annual report.

Continue Group Health Plan Coverage

- Continue health care coverage for yourself, spouse or dependents if there is a loss of coverage under the Plan as a result of a qualifying event. You or your dependents may have to pay for such coverage. Review this SPD and the documents governing the Plan on the rules governing your COBRA continuation coverage rights.

- Effective January 1, 2011, the health plans contain no pre-existing condition limitations.

Prudent Actions by Plan Fiduciaries

In addition to creating rights for Plan participants, ERISA imposes duties upon the people who are responsible for the operation of the Plan. The people who operate the Plan, called "fiduciaries" of the Plan, have a duty to do so prudently and in the interest of you and other Plan participants and beneficiaries. No one, including your employer, your union, or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a benefit or from exercising your rights under ERISA.

Enforce Your Rights

If your claim for a benefit is denied or ignored, in whole or in part, you have a right to know why this was done, to obtain copies of documents relating to the decision without charge, and to appeal any denial, all within certain time schedules.

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of Plan documents or the latest annual report from the Plan and do not receive the materials within 30 days, you may file suit in a Federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to $110 a day until you

receive the materials, unless the materials were not sent because of reasons beyond the control of the Plan Administrator. If you have a claim for benefits, which is denied or ignored, in whole or in part, you may file suit in Federal court. In addition, if you disagree with the Plan's decision or lack thereof concerning the qualified status of a medical child support order, you may file suit in a Federal court. If it should happen that Plan fiduciaries misuse the plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a Federal court. The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

Assistance With Your Questions

If you have any questions about your Plan, you should contact the Plan Administrator. If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the Plan Administrator, you should contact the nearest area office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in your telephone directory or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue N.W., Washington D.C. 20210. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration.

RIGHT TO AMEND OR TERMINATE PLAN

The Company reserves the right at any time, without prior or other approval of any employee or former employee, to change, modify, amend or terminate all or any part of the Plan, including any benefit option (subject to the applicable provisions of the insurance contracts, if any), at any time and in any manner deemed necessary or desirable by the Company.

POWER AND AUTHORITY OF INSURER

Certain benefits under this Plan are fully insured. Fully insured benefits are provided under a group insurance contract entered into between the Company and an insurer. Claims for benefits under the fully insured benefit options are sent to the applicable insurer. The insurer is solely responsible for paying claims for the fully insured benefit options under the Plan, not the Company.

The insurer is responsible for (1) determining eligibility for and the amount of any benefits payable under a fully insured benefit option under the Plan and (2) prescribing claims procedures to be followed and the claims forms to be used by employees for a fully insured benefit option under the Plan.

An insurer also has the authority to require participants to furnish such information as it determines is necessary for the proper administration of fully insured benefit options under the Plan.

Additionally, an insurer may cancel an insurance policy for a fully insured benefit option under the Plan for non-payment of premiums and in other circumstances. Any failure of a fully insured

benefit option to provide insurance benefits, whether due to the Company's negligence, gross neglect, or otherwise, including but not limited to failure to enroll a participant or pay premiums, shall not result in any liability on the part of the Company to a participant. Coverage under a fully insured benefit option shall terminate in accordance with the terms of the insurance policy (and the Plan, as applicable).

APPENDIX A

The following Booklets are incorporated by reference and are included as part of this Summary Plan Description. If you do not have a copy of a Booklet, please contact your Plan Administrator.

Type of Benefit	Booklet	Funding
Dental	Aetna Dental	Self-Insured
Health	Anthem Medical	Self-Insured
Prescription	Caremark Prescription Drug Plan	Self-Insured
Health	HMSA BCBS Hawaii	Insured
Long Term Disability	Standard Insurance Co	Insured
Life / AD&D	Standard Insurance Co	Insured
Travel & Accident	CHUBB	Insured
Medical Benefits Abroad	CIGNA International	Insured
Expatriate Benefits Program	Aetna International	Insured
Dependent Care Spending Account	STERIS Dependent Care Assistance Summary Plan Description	Self-Insured
Medical Care Spending Account and Pre-Tax Payment of Certain Plan Premiums	STERIS Flexible Benefits Plan Summary Plan Description	Self-Insured

January 1, 2015

APPENDIX B

The employees eligible to participate in the STERIS Corporation Welfare Benefit Plan, the STERIS Corporation Flexible Benefits Plan, or the STERIS Corporation Dependent Care Assistance Plan are:

1. Full-time non-union employees of Integrated Medical Systems International, Inc. and Wedge Manufacturing, Inc. who are regularly scheduled to work at least 30 hours per week.

2. Full-time non-union employees of any Employer located in Hawaii who are regularly scheduled to work at least 40 hours per week.

3. Full-time non-union employees of all other Employers who are regularly scheduled to work at least 40 hours per week; part-time non-union employees of all other Employers who are regularly scheduled to work from 30-39 hours per week; and part-time non-union employees of all other Employers who are regularly scheduled to work from 20-29 hours per week.

4. Full-time or part-time employees of an Employer who are covered by a collective bargaining agreement to which an Employer is a party, and which provides for the employee's participation in the Plan, in accordance with the provisions of the collective bargaining agreement.

The following persons are not eligible to participate in the STERIS Corporation Welfare Plan, the STERIS Corporation Flexible Benefits Plan, or the STERIS Corporation Dependent Care Assistance Plan:

1. Employees who are non-resident aliens and receive no earned income from an Employer that constitutes income from sources within the United States.

2. Part-time employees who are not included in any category of eligible employees above.

3. Temporary employees or consultants.

4. Employees who are covered by a collective bargaining agreement to which an Employer is a party that does not provide for the employee's participation in the Plan.

5. Employees who are self-employed individuals as described in Section 401(c) of the Code including sole proprietors, partners in a partnership, or more than 2% owners of subchapter "S" Corporations.

EXHIBIT B

Commitment to Regulatory, Quality and Safety Compliance

At STERIS, we take our responsibility for public health and the safety of patients and providers very seriously. We strive for excellence in everything that we do – and, we are committed to compliance with established legal and ethical standards.

STERIS Healthcare Products provides infection prevention and procedural solutions for healthcare providers worldwide, including capital equipment and related maintenance and installation services, as well as consumables. STERIS Applied Sterilization Technologies is a leading global provider of contract sterilization services for medical device and pharmaceutical Customers and others. STERIS Healthcare Specialty Services provides a range of specialty services for healthcare providers including hospital sterilization services, instrument and endoscope repairs, and linen management. STERIS Life Sciences manufactures capital equipment and consumable products, and provides equipment installation, maintenance, repair and specialty services, for pharmaceutical manufacturers and research institutions worldwide.

With a long list of first-to-market products and industry leading innovations, STERIS is a global leader in infection prevention, contamination control and surgical care technologies. We are committed to providing our Customers throughout the world with safe, effective, quality products and services. When it's a matter of life and death, patients and their families count on the expertise of caring professionals. And those professionals count on STERIS. Our goal is to help ensure

that the environments in hospitals, surgical centers and pharmaceutical and research laboratories allow every patient to receive vital care without undue risk of infection or contamination.

To achieve this goal, STERIS has a broad range of programs that address product and service quality, safety, performance and regulatory compliance.

Regulatory Compliance

STERIS follows strict regulatory compliance and quality standards to ensure the safety and supply of our products and services. Our regulatory, quality and safety processes and procedures are broad in scope and apply stringent standards – from the quality of incoming materials through the design, development, manufacture, storage, handling and distribution of our products and delivery of services.

STERIS operates under many U.S. and international governing standards including but not limited to the following:

United States

- FDA 21 CFR 820 – U.S. Quality System Regulation Good Manufacturing Practice for Medical Devices (QSR)
- FDA 21 CFR 211: U.S. Current Good Manufacturing Practice for Finished Pharmaceuticals (cGMP)
- FDA 21 CFR 1271.150-320: Current Good Tissue Practice Requirements (cGTP)
- U.S. Environmental Protection Agency – 40 CFR 150-189: Pesticide Programs
- OSHA – U.S. Occupational Safety and Health Administration
- NRC – U.S. Nuclear Regulatory Commission

International

- ISO 13485 – Medical Devices Quality Management System Requirements
- ISO 9001 – Quality Management Systems – Requirements
- BS EN 14065 – Textiles – Laundry processed textiles – Biodecontamination control system
- ISO 19011 – Guidelines for Auditing Management Systems
- EU Medical Device Directive (MDD)
- European Chemicals Agency (EChA)
- EU Biocidal Products Regulation
- U.K. Medicine and Healthcare Products Regulatory Agency (MHRA)
- Health Canada – Canadian Medical Device Regulations (CMDR)
- Health Canada – Good Manufacturing Practices Guidelines – Pharmaceuticals (cGMPs)
- Australian Therapeutic Goods Administration (TGA)
- Japan Pharmaceutical and Medical Devices Agency (PMDA) – Pharmaceutical Affairs Law

To monitor compliance with these standards, internal and third-party assessments of our quality and regulatory systems are conducted. FDA conducts inspections of our manufacturing and contract sterilization facilities on a periodic basis to confirm compliance to device QSRs, drug cGMPs and human tissue cGTPs. Similar governmental inspections are conducted in our manufacturing locations outside the U.S.

Our EU Notified Body and Quality System Registrars conduct annual independent assessments of our ISO certified manufacturing, contract sterilization and healthcare specialty facilities to audit compliance with ISO 13485, ISO 9001, BS EN 14065 and EU CE marking requirements under the EU MDD as applicable. Each year STERIS hosts numerous Notified Body assessments at our various facilities, as well as additional audits by many of our Customers who are themselves manufacturers.

The STERIS Corporate Internal Audit Department conducts regular Quality and Regulatory audits in our manufacturing facilities. The results are reported to both the Audit Committee and the Compliance Committee of the Company's Board of Directors. We also engage third-party independent auditors to conduct Quality and Regulatory audits.

Robust processes are in place to monitor and support compliance with product and service regulations worldwide, including design controls, review of product changes, labeling and advertising, marketing approvals, good manufacturing practices, and adverse event reporting requirements.

Quality Policy

STERIS is committed to delivering satisfaction to our Customers by anticipating their needs and offering value, quality, and reliability that exceeds their expectations.

The success of STERIS and our Customers is powered by our people, a culture of teamwork, innovative solutions, and by continually improving the effectiveness of our Quality System as a foundation for business performance.

We value safety, integrity and mutual respect, supporting our employees, communities and customers, complying with all applicable laws and regulations.

This is the STERIS Way, a culture of quality.

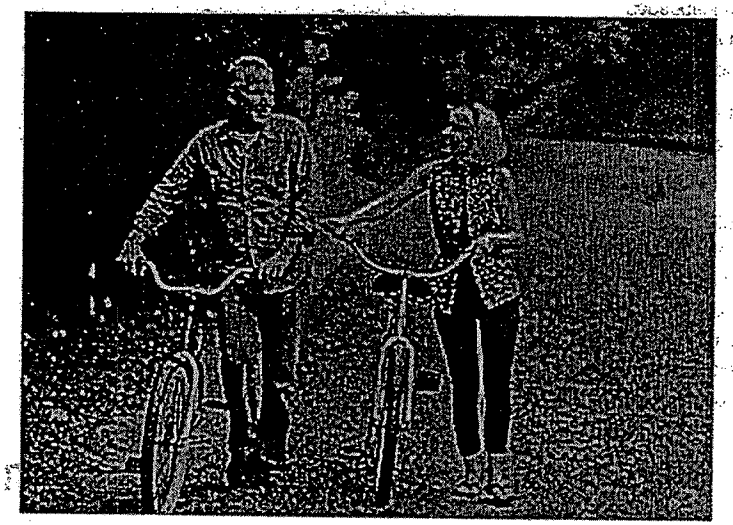
Quality and Regulatory Leadership

Kathie Bardwell, Senior Vice President & Chief Compliance Officer, leads Corporate Internal Audit, Security and Regulatory Affairs for STERIS Healthcare, and Quality and Regulatory Affairs for the STERIS Applied Sterilization Technologies business unit.
Regulatory and Compliance inquiries should be directed to 440-392-7163.

Greg Meunier, Vice President, Customer Quality, is qualified in Continuous Improvement methodology and leads STERIS's quality system initiatives.

Product Quality inquiries should be directed to 440-392-7670.

EXHIBIT C



2016

Benefit Eligibility & Enrollment

TABLE OF CONTENTS

WELCOME TO STERIS CORPORATION

STERIS offers eligible full-time employees a comprehensive, high quality and flexible benefits program designed to meet their individual needs. In fact, national surveys consistently show STERIS's benefits program is much better than what is offered nationwide by most other large employers. The benefits program includes:

- Medical
- Prescription Drug
- Vision
- Dental
- Employee Assistance Program (EAP)
- Healthcare Flexible Spending Account (Health FSA)
- Dependent Day Care Flexible Spending Account (Dependent FSA)
- Health Savings Accounts (HSA)
- Life Insurance
- 401(k) Plan
- Tuition Reimbursement
- Paid Time Off
- Short Term Disability
- Long Term Disability
- Business Travel Accident Insurance
- International Business Medical & Travel Assistance
- Social Security
- Medicare
- Workers' Compensation
- Unemployment Compensation

Take time to learn about your benefits – they add significant value to your total rewards at STERIS.

In addition to the materials in this packet, more information, including Summary Plan Descriptions, is available at www.sterisbenefitsconnection.com. USERNAME: STERIS, PASSWORD: STEBENEFITS. You may also call the STERIS Benefits Help Line at 1-877-354-5755 or send an email to benefits@steris.com.

Your Health Benefit Eligibility and Enrollment

You must be a regular employee to be eligible for coverage. Your coverage may be effective as soon as 30 days from your date of hire. For example, a new employee hired on March 30 will be eligible for coverage on April 29.

To become covered on your effective date, the new hire enrollment form must be returned within 30 days from your date of hire. The benefit choices you make when you are newly eligible for benefits at STERIS remain in effect for the entire plan year (through December 31). If you do not return your new hire employee benefits enrollment form in a timely manner, you waive your opportunity to enroll in coverage until the next annual open enrollment period (usually held in November), unless you experience a Qualified Life Event (QLE) as defined by the Internal Revenue Service (IRS).

An IRS Qualified Life Event (QLE) allows you to change your coverage during the year. Examples of a QLE include marriage or divorce, birth or adoption of a child, death of a dependent or gain or loss of your spouse's employment or benefits. Any change due to a QLE must be completed within 60 days of the date of the qualifying event. You will be required to provide documentation of the QLE and proof of eligibility for those dependents you wish to cover.

Dependents that are eligible for coverage include your legal spouse, your natural or adopted adult children under age 26 or disabled children of any age. Step, foster and custodial children may be covered until age 19. All dependents added to your coverage will be required to provide documentation of dependent eligibility and may be asked to verify their continued eligibility from time to time. Examples of valid documentation include government issued birth certificates and marriage certificates. Call the Benefits Help Line at 1-877-354-5755 for more information on dependent eligibility.

What to Do Next

- Review the information contained here
- Decide if you want coverage for any dependents. If you do cover dependents, provide documentation for each dependent you wish to cover (e.g., birth or marriage certificate) when you submit your enrollment form.
- To enroll or decline coverage, purchase additional group term life insurance or participate in a Flexible Spending Account or Health Savings Account, complete the 2016 Employee Benefits Enrollment Form and return it to the Benefits Department within 60 days from your date of hire.

 10.23.15

YOUR HEALTH PLAN OPTIONS

You may choose from three affordable Anthem plans. Two are Preferred Provider Organization (PPO) plans: The Premium Plan and the Core Plan. The third is a High Deductible Health Plan (HDHP) with an employer-funded Health Savings Account, or HSA, called the Gold Plan. Each plan provides high quality healthcare services and access to the same network of providers; however, all three have different deductibles, co-insurance and payroll deductions. Co-payments for Primary Care office visit are $25 and Specialist office visits are $40 for the Premium and Core Plans. The Gold Plan has no office visit co-pay; instead, co-insurance applies after the deductible is met for office visits. You must also meet the Gold Plan deductible before prescription drugs are covered. All plans include 100% coverage for Anthem recommended preventive care services.

You have four coverage levels from which to choose:

- Employee only, if you are single or if other members of your family have their own coverage
- Employee and spouse
- Employee and child(ren)
- Employee and family (spouse and child(ren))

Your payroll deduction depends on the plan and coverage level you choose. To decide which plan is best for you, consider your healthcare needs, the payroll deduction amounts and the out-of-pocket expenses (deductibles and co-insurance), that you may be required to pay when you need care. (See Fig. A)

The Anthem Healthcare Comparison Chart provides summary information about each medical plan so you can compare your options. (See Fig. B)

Fig. A: 2016 Medical Weekly Employee Payroll Deductions* (includes Prescription and Vision)

Anthem PPO Plans	Employee Only	Employee + Spouse	Employee + Child(ren)	Employee + Family
Premium	$30	$77.87	$50	$103.85
Core	$11	$34.62	$20	$47.54
Gold	$10	$33.46	$20	$43.38

* Multiply by 2 for bi-weekly payroll Deductions

Fig. B: 2016 Anthem Healthcare Comparison Chart

Benefit (No Lifetime Maximums)	Premium Plan		Core Plan		Gold Plan with HSA	
	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network	Out-of-Network
Annual Deductible						
Individual	$500	$1,000	$750	$1,500	$1,500	$3,000
Family	$1,000	$2,000	$1,500	$3,000	$3,000	$6,000
Coinsurance	85%	65%	80%	60%	80%	60%
Annual Out-of-Pocket Max (includes deductible and co-pays for medical and prescription drugs)						
Individual	$2,750	$5,500	$3,250	$6,500	$3,350	$6,700
Family	$5,500	$11,000	$6,500	$13,000	$6,650	$13,400
Physician and Hospital Services (Anthem recommended preventative care from network providers is 100% covered)						
Primary Care Office Visit	100% after $25 co-pay	65% after deductible	100% after $25 co-pay	60% after deductible	80% after deductible	60% after deductible
Specialist Office Visit	100% after $40 co-pay	65% after deductible	100% after $40 co-pay	60% after deductible	80% after deductible	60% after deductible
X-ray and Lab (in physician's office)	100%	65% after deductible	100%	60% after deductible	80% after deductible	60% after deductible
Hospital Inpatient/Outpatient and X-ray and Lab	85% after deductible	65% after deductible	80% after deductible	60% after deductible	80% after deductible	60% after deductible
Emergency Room (Emergency Use Only)	100% after $150 co-pay	100% after $150 co-pay	100% after $150 co-pay	100% after $150 co-pay	80% after deductible	80% after deductible
Prescription Drugs	30% co-insurance, subject to minimums and maximums and based on tier (e.g. generic and brand)				80% after deductible	60% after deductible
Anthem Blue View Vision Plan	Vision plan benefits included when enrolled in an Anthem medical plan. See page 4 for vision plan features.					

Gold High Deductible Health Plan or HDHP

The Gold Plan is a High Deductible Health Plan (HDHP) with a Health Savings Account (HSA). The Gold Plan offers the same access to Anthem providers and 100% coverage for recommended wellness exams and preventive screenings from Anthem providers.

Compared to a traditional PPO Plan:

- The Gold Plan has a higher deductible: $1,500 for individual coverage and $3,000 for family coverage.
- The Gold Plan family deductible works differently: If you enroll in family coverage, the family must meet the entire $3,000 deductible before any benefits are paid for any covered family members.
- The Gold Plan covers prescription drugs, too. This means that you must meet the deductible before prescription drugs are covered, unless they qualify as preventive care.
- The Gold Plan includes a Health Savings Account, or HSA. You may make convenient pre-tax payroll deductions up to IRS limits.
- STERIS's HSA contributions are $500/year for Employee Only and Employee & Spouse coverage, and $1,000/year for Employee & Child and Employee & Family coverage.

Anthem Online Resources

Visit www.anthem.com to view a list of in-network providers, the status of your claims, Explanation of Benefits (EOB), covered dependents, year-to-date deductible information or to order ID cards. Click on "Find a Doctor" to search the National BlueCard Directory.

Anthem Blue View Vision

If you are enrolled in an Anthem healthcare plan, you will be automatically enrolled in the Blue View Vision Plan at the same coverage level (for example, employee only, employee plus spouse, etc.) at no additional cost.

Blue View Vision offers you a network of more than 32,000 providers which include optometrists, ophthalmologists and opticians at independent practices and leading retailers such as Target, JC Penney, Sears, 1-800-CONTACTS, LensCrafters and Pearle Vision.

To obtain benefits, visit the Blue View Vision provider of your choice and present your Anthem Medical ID card at the time of service. The chart below summarizes plan features.

Anthem
Customer Service
1-800-749-5473
Network
National Accounts
24-Hour Nurse Line
1-888-596-9473
Website
www.Anthem.com

Anthem Employee Assistance Program (EAP)
Customer Service
1-800-865-1044
Website
www.AnthemEAP.com
Member Login: **STERIS**

Anthem Blue View Vision
Customer Service
866-723-0515
Website
www.Anthem.com

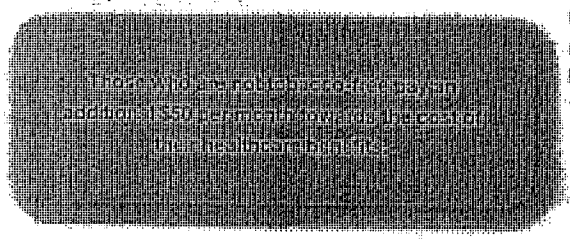
Anthem Blue View Vision Plan

Plan Feature	Benefit Period	In-Network Benefit	Out-of-Network Benefit
Routine eye exam	Once every 12 months	Paid in Full	$42 Reimbursement
Contact lenses fitting		Up to $55 Allowance	N/A
Standard lenses		Paid in full after $25 co-payment	$40 Reimbursement (Single) $60 Reimbursement (Bifocal) $80 Reimbursement (Trifocal)
Contact lenses (instead of standard lenses)		Up to $130 Allowance	$105 Reimbursement
Eyeglass frames	Once every 24 months	Up to $130 Allowance	$45 Reimbursement

NOTE: Progressive lenses and tints, coatings and polycarbonate lenses for adults require additional fees. The benefit period renews from date of last service.

Tobacco-Free Requirement

STERIS has a tobacco-free requirement which applies to all enrolled employees and spouses — regardless of frequency of tobacco use. Tobacco use includes: cigarettes, e-cigarettes, cigars, pipes and chewing tobacco products.



Tobacco Cessation Program

STERIS provides a Tobacco Cessation Program to support all employees and enrolled spouses in becoming 100% tobacco free.

Anthem provides on-line tools and telephonic counseling through the Anthem Employee Assistance Program (EAP). In addition, Caremark provides benefits for a selection of generic tobacco cessation prescription drugs and over-the-counter nicotine replacement therapies prescribed by your physician at no cost. Quantity limits apply.

Dental Plan Coverage

STERIS offers comprehensive dental coverage at competitive rates through the Aetna Dental PPO Plan, a national dental provider. The Aetna Dental PPO includes both in-network and out-of-network coverage with the flexibility to go to any licensed dentist. Generally, if you use an in-network dentist, you will pay less for covered services. Preventive services (cleanings and exams) are covered at 100%. The charts below summarize the dental plan.

Aetna Dental Plan
Weekly Employee Payroll Deductions

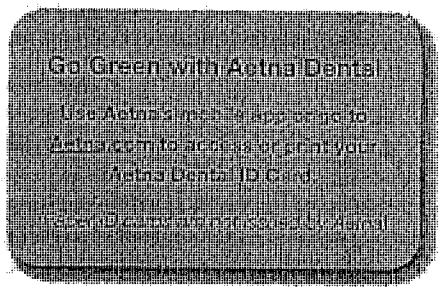
Employee Only	Employee + Spouse	Employee + Child(ren)	Employee + Family
$2.77	$5.77	$5.77	$8.77

Aetna Dental PPO Summary

	In-Network	Out-of-Network
Deductible	$50 single / $150 family	
Preventive Services (cleaning, x-rays) – Not subject to deductible	100%	100%
Basic Restorative Services (fillings)	90%	80%
Major Restorative Services (bridges, crowns, implants)	60%	50%
Orthodontic Services (Coverage for children up to 19 only)	50%	50%
Annual per person maximum benefit	$1,500	
Lifetime per child maximum orthodontia limit (Coverage up to age 19)	$1,500	

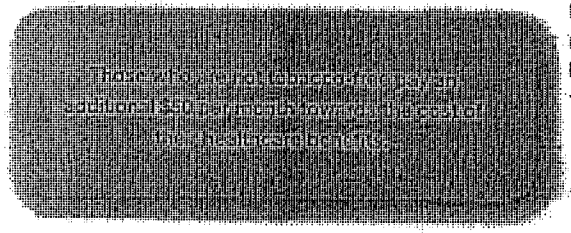
Anthem
Tobacco Cessation
1-800-865-1044

Aetna Dental
Customer Service
1-877-368-6605
Website
www.Aetna.com



Tobacco-Free Requirement

STERIS has a tobacco-free requirement which applies to all enrolled employees and spouses — regardless of frequency of tobacco use. Tobacco use includes: cigarettes, e-cigarettes, cigars, pipes and chewing tobacco products.



Tobacco Cessation Program

STERIS provides a Tobacco Cessation Program to support all employees and enrolled spouses in becoming 100% tobacco free.

Anthem provides on-line tools and telephonic counseling through the Anthem Employee Assistance Program (EAP). In addition, Caremark provides benefits for a selection of generic tobacco cessation prescription drugs and over-the-counter nicotine replacement therapies prescribed by your physician at no cost. Quantity limits apply.

Dental Plan Coverage

STERIS offers comprehensive dental coverage at competitive rates through the Aetna Dental PPO Plan, a national dental provider. The Aetna Dental PPO includes both in-network and out-of-network coverage with the flexibility to go to any licensed dentist. Generally, if you use an in-network dentist, you will pay less for covered services. Preventive services (cleanings and exams) are covered at 100%. The charts below summarize the dental plan.

Aetna Dental Plan
Weekly Employee Payroll Deductions

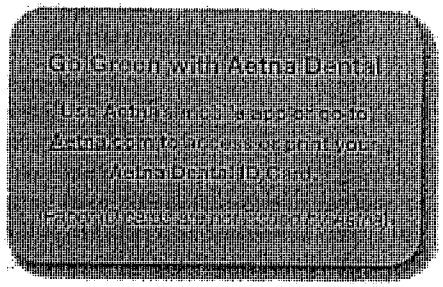
Employee Only	Employee + Spouse	Employee + Child(ren)	Employee + Family
$2.77	$5.77	$5.77	$8.77

Aetna Dental PPO Summary

	In-Network	Out-of-Network
Deductible	$50 single / $150 family	
Preventive Services (cleaning, x-rays) – Not subject to deductible	100%	100%
Basic Restorative Services (fillings)	90%	80%
Major Restorative Services (bridges, crowns, implants)	60%	50%
Orthodontic Services (Coverage for children up to 19 only)	50%	50%
Annual per person maximum benefit	$1,500	
Lifetime per child maximum orthodontia limit (Coverage up to age 19)	$1,500	

Anthem
Tobacco Cessation
1-800-865-1044

Aetna Dental
Customer Service
1-877-368-6605
Website
www.Aetna.com



so HSA funds become available to pay eligible medical expenses not covered by your health plan once they have been deposited to your account.

STERIS's HSA Contributions

Coverage Level	STERIS Annual HSA Contribution *(earned and deposited each pay period)*
Employee Only	$500
Employee + Spouse	$500
Employee + Child(ren)	$1,000
Employee + Family	$1,000

You have the option of making pre-tax contributions to your HSA, subject to the IRS's 2016 maximum amounts of $3,350 if you enroll in employee-only coverage or $6,750 if you cover yourself and one or more dependents. The IRS annual maximum includes STERIS's contributions, so the maximum amount you can contribute must be reduced by the amount STERIS contributes (See Fig.C). You can choose to contribute less than these amounts or nothing at all, but you may not exceed them. If you exceed the annual IRS HSA maximum, you will pay income tax plus a 6% penalty on the excess amount.

Fig. C

Coverage Level	Your 2016 maximum voluntary HSA contribution amount
Employee Only	$2,850
Employee + Spouse	$6,250
Employee + Child(ren)	$5,750
Employee + Family	$5,750

NOTE: Assumes consistent coverage and coverage level for full calendar year. Other rules apply for mid-year hires and changes, including separation from service.

Extra Contributions for Ages 55+

In any year in which you are 55 or older, you are eligible to make an additional $1,000 in HSA contributions.

The Money in Your HSA is Yours

All the money in the HSA – including the contributions made by STERIS – is yours, even if you leave your job, enroll in a health plan which is not HSA-qualifying, or retire. In other words, the HSA is not a "use-it-or-lose-it" account. For this reason, some people use the HSA as an additional savings account for retirement.

You Can Grow Your Account through Saving or Investing

You decide how and when to use your HSA, including whether to save it for later or spend it for current health care expenses. As your balance rolls forward from year to year, it earns interest. When your balance reaches $1,000, you can invest future amounts – tax free – in mutual funds. HealthEquity offers you a platform of mutual funds including low cost Vanguard index options.

There's no cost to open the account, and, in 2016, as long as you are an active employee, STERIS will pay the $2.75 monthly fee. Investment management and other administrative costs may apply (e.g. paper copies, etc.).

You Gain Triple-Tax Savings

Contributions to the HSA are tax-free for you – whether they come from you or from STERIS (that includes Medicare and Social Security taxes in addition to Federal and most State Income taxes).

- Your HSA account and investment earnings are tax-free and roll over from year-to-year.
- You can withdraw your money tax-free at any time as long as you use it for qualified medical expenses.

You are eligible to participate in the HSA and receive STERIS's contribution if you enroll in the new Gold plan. If you enroll in the Premium or Core PPO plans you are NOT eligible to participate in the HSA. You are also not eligible to participate in an HSA if:

- you are enrolled in Medicare; or,
- you can be claimed on another individual's tax return; or,
- you are covered by another health care plan which does not qualify as a High Deductible Health Plan.

What expenses may be reimbursed through the HSA

You may use your HSA funds to pay for qualified medical expenses incurred by you, your spouse or persons you claim on your tax return. Qualified medical expenses are costs defined in IRS Publication 502 that are not covered by your health plan, such as deductibles and co-insurance. Generally, these are the same expenses eligible for reimbursement from a Flexible Spending Account (FSA), with the addition of reimbursement for payments you may make in the future for Medicare Part B premiums.

Special Rules: FSAs and HSAs

If you participate in the HSA, you may not also participate in a Flexible Spending Account (FSA) for medical expenses. You may however, establish a "limited purpose" FSA, pay for eligible unreimbursed dental and vision expenses.

Consult with an Expert: Contact HealthEquity

To decide if the new Gold Plan with HSA is right for you and/or determine the amount of HSA contributions you may wish to make, visit www.healthequity.com/ed/steris or call HealthEquity anytime of the day or night at 866-346-5800 for expert consultation and advice.

If you choose the Gold Plan, a Health Savings Account (HSA) will be automatically opened for you at HealthEquity, the nation's largest and most experienced HSA administrator.

HealthEquity
Customer Service
866-346-5800
Website
www.healthequity.com/ed/steris

so HSA funds become available to pay eligible medical expenses not covered by your health plan once they have been deposited to your account.

STERIS's HSA Contributions

Coverage Level	STERIS Annual HSA Contribution *(earned and deposited each pay period)*
Employee Only	$500
Employee + Spouse	$500
Employee + Child(ren)	$1,000
Employee + Family	$1,000

You have the option of making pre-tax contributions to your HSA, subject to the IRS's 2016 maximum amounts of $3,350 if you enroll in employee-only coverage or $6,750 if you cover yourself and one or more dependents. The IRS annual maximum includes STERIS's contributions, so the maximum amount you can contribute must be reduced by the amount STERIS contributes (See Fig.C). You can choose to contribute less than these amounts or nothing at all, but you may not exceed them. If you exceed the annual IRS HSA maximum, you will pay income tax plus a 6% penalty on the excess amount.

Fig. C

Coverage Level	Your 2016 maximum voluntary HSA contribution amount
Employee Only	$2,850
Employee + Spouse	$6,250
Employee + Child(ren)	$5,750
Employee + Family	$5,750

NOTE: Assumes consistent coverage and coverage level for full calendar year. Other rules apply for mid-year hires and changes, including separation from service.

Extra Contributions for Ages 55+

In any year in which you are 55 or older, you are eligible to make an additional $1,000 in HSA contributions.

The Money in Your HSA is Yours

All the money in the HSA – including the contributions made by STERIS – is yours, even if you leave your job, enroll in a health plan which is not HSA-qualifying, or retire. In other words, the HSA is not a "use-it-or-lose-it" account. For this reason, some people use the HSA as an additional savings account for retirement.

You Can Grow Your Account through Saving or Investing

You decide how and when to use your HSA, including whether to save it for later or spend it for current health care expenses. As your balance rolls forward from year to year, it earns interest. When your balance reaches $1,000, you can invest future amounts – tax free – in mutual funds. HealthEquity offers you a platform of mutual funds including low cost Vanguard index options.

There's no cost to open the account, and, in 2016, as long as you are an active employee, STERIS will pay the $2.75 monthly fee. Investment management and other administrative costs may apply (e.g. paper copies, etc.).

You Gain Triple-Tax Savings

Contributions to the HSA are tax-free for you – whether they come from you or from STERIS (that includes Medicare and Social Security taxes in addition to Federal and most State Income taxes).

- Your HSA account and investment earnings are tax-free and roll over from year-to-year.
- You can withdraw your money tax-free at any time as long as you use it for qualified medical expenses.

You are eligible to participate in the HSA and receive STERIS's contribution if you enroll in the new Gold plan. If you enroll in the Premium or Core PPO plans you are NOT eligible to participate in the HSA. You are also not eligible to participate in an HSA if:

- you are enrolled in Medicare; or,
- you can be claimed on another individual's tax return; or,
- you are covered by another health care plan which does not qualify as a High Deductible Health Plan.

What expenses may be reimbursed through the HSA

You may use your HSA funds to pay for qualified medical expenses incurred by you, your spouse or persons you claim on your tax return. Qualified medical expenses are costs defined in IRS Publication 502 that are not covered by your health plan, such as deductibles and co-insurance. Generally, these are the same expenses eligible for reimbursement from a Flexible Spending Account (FSA), with the addition of reimbursement for payments you may make in the future for Medicare Part B premiums.

Special Rules: FSAs and HSAs

If you participate in the HSA, you may not also participate in a Flexible Spending Account (FSA) for medical expenses. You may however, establish a "limited purpose" FSA, pay for eligible unreimbursed dental and vision expenses.

Consult with an Expert: Contact HealthEquity

To decide if the new Gold Plan with HSA is right for you and/or determine the amount of HSA contributions you may wish to make, visit www.healthequity.com/ed/steris or call HealthEquity anytime of the day or night at 866-346-5800 for expert consultation and advice.

If you choose the Gold Plan, a Health Savings Account (HSA) will be automatically opened for you at HealthEquity, the nation's largest and most experienced HSA administrator.

HealthEquity
Customer Service
866-346-5800
Website
www.healthequity.com/ed/steris

Flexible Spending Accounts

Flexible Spending Accounts (FSA) are tax advantaged accounts which allow you to set aside funds from each paycheck on a pre-tax basis to pay for out-of-pocket medical, dental, prescription drug and vision care expenses, as well as certain dependent day care expenses. Healthcare and Dependent Day Care FSAs are optional and you decide each year whether or not to enroll. To participate in an FSA, you must re-enroll each year.

Healthcare FSA Example

Dental Charges	$4,050
STERIS Dental Plan Payment	($1,500)
Un-reimbursed Expense	$2,550
Estimated Savings Based on Your Taxable Income $637.50 ($2,550 X 25% federal tax)	

The example above and Fig. D shows how a Healthcare FSA can help you reduce your taxes and increase your take home pay.

The amount you contribute to an FSA is not counted as part of your income for federal or state income tax and so reduces your taxable income. Because of this tax advantage, the IRS places limits on the amount you may contribute and when and how you use the money.

FSA Options

Automatic Reimbursement. If you participate in the Healthcare FSA and are enrolled in an Anthem Medical Plan, you will be automatically reimbursed (up to your annual maximum) for any eligible medical or prescription drug expenses not covered, at all or in part, by the plan. If you opt out of this feature or if you do not participate in an Anthem plan, you must complete and submit a Reimbursement Request Form with proper proof of service/purchase to Anthem by mail or by fax or by on-line submission. You must also submit a Reimbursement Request Form for out-of-pocket dental and vision expenses.

Direct Deposit Option. You may have your FSA reimbursements deposited directly into your checking or savings account. To set up direct deposit, login to www.benefitadminsolutions.com and click on the "Add/Update ACH" link on the main Reimbursement Account Web Page. You may also call 1-877-233-7040 to request a direct deposit form.

FIG. D How an FSA can help you.

FSA Feature	Healthcare	Dependent Day Care
Min./Max. Plan Year Annual Contribution	$250 min. / $2,550 max.	$250 min. / $5,000 max.
Funds Available	Full amount January 1	As deposited
Date of Service must be between*	January 1, 2016 – March 15, 2017	January 1, 2016 – March 15, 2017
Claims must be filed by*	April 30, 2017	April 30, 2017
Use your account to pay for	Out-of-pocket expenses including: Co-payments, deductibles, dental, vision and prescription drug. Reimbursement for over the counter medications requires a prescription. **NOTE: If you enroll in the Gold Plan with HSA, you may establish a limited purpose FSA for dental and vision expenses only.**	Eligible child or elder dependent day care expenses while you and your spouse work or attend school full time. Eligible dependents include: • Children under the age of 13 who are included on your federal income tax return and living with you in a parent/child relationship • A spouse or dependent parent claimed on your federal income tax return who is physically or mentally unable to take care of himself/herself and who normally spends at least eight hours a day in your home.
"Use It or Lose It"	Any unused funds are forfeited under IRS rules	Any unused funds are forfeited under IRS rules

*Other rules apply if you separate from service mid-year. Contact the Benefits Department for more information.

Employee Assistance Program (EAP)

STERIS provides all employees and their household members with free and confidential access to an Employee Assistance Program (EAP). Offered through Anthem Behavioral Health, the EAP provides up to four visits per year of confidential counseling, education and referral services for each member of your household. Topics include a broad range of personal issues, including depression, substance abuse, relationship concerns and parenting issues.

There are also unlimited referrals for legal, financial and child/elder care available. In addition, the Anthem EAP website offers a host of interactive tools, including quizzes, self-assessments, WebMD wellness information and resources, as well as special offers and discounts on weight loss, smoking cessation and health club plans.

STERIS Life Insurance and Accidental Death and Dismemberment Insurance

STERIS provides basic group term life (GTL) insurance and accidental death and dismemberment (AD&D) insurance, each equal to two times your annual base pay (rounded up to the nearest thousand), up to a maximum of $150,000. This insurance is administered by The Standard. There is no cost to you. Life insurance provides payment upon the death of the insured. AD&D insurance provides payment in the event of accidental death or injury to the insured person.

The cost of Company-provided life insurance for coverage greater than $50,000 is taxable. This is called Imputed Income Liability and will be coded on your paycheck stub as "Group Term Life." Imputed Income Liability does not apply to the AD&D coverage. Since you are taxed on the value of life insurance provided by STERIS that exceeds $50,000, you may choose to reduce this company provided life insurance coverage to $50,000. If you choose to reduce your life insurance coverage to $50,000, you may not change it again while employed at STERIS.

IMPORTANT
You must be actively at work to activate initial life and LTD insurance coverage or any increases approved by The Standard.

10.23.15

Employee Optional Group Term Life (GTL) Insurance

Within the first 30 days of hire into an eligible position, you may apply to purchase insurance in amounts equal to one to three times your annual salary without completing an Evidence of Insurability (EOI) form. After 30 days, or if you wish to purchase insurance of three to six times your salary, up to a maximum of $500,000, you must complete an EOI form and return it to The Standard.

The cost of the optional life insurance is based on your age as of January 1 of each year. Rates are subject to change annually. Fig. E: Employee and Spouse Optional GTL rates shows the current cost per month for each $1,000 of coverage.

You may request optional life insurance any time during the year by completing a Life Insurance and AD&D Change Form found on the STERISbenefitsconnection.com page or you can request a form from your HR representative. Then, Evidence of Insurability (EOI) instructions will be sent to you by the Benefits Department, and should be returned directly to The Standard for review and processing. The personal information provided on the EOI will determine whether you are approved for the additional coverage, required to take a physical examination, or refused coverage based on The Standard's underwriting guidelines.

Fig. E: Employee and Spouse Optional GTL Rates

Employee/Spouse Age	Life Insurance Cost per $1,000 of coverage per month
Under 30	$0.08
30-34	$0.10
35-39	$0.12
40-44	$0.14
45-49	$0.20
50-54	$0.30
55-59	$0.55
60-64	$0.85
65-69	$1.48
70 and older	$2.64

To calculate the monthly cost, divide your desired coverage amount by 1,000 and then multiply by the appropriate monthly rate (e.g., a 30 yr. old wants $115,000 in life insurance: $115,000 ÷ 1,000 = 115 x .10 = $11.50 cost per month).

Spouse Optional GTL Insurance

Life insurance coverage is available for your spouse if you elect optional life insurance for yourself. Your spouse may choose up to $250,000 in coverage, but the coverage cannot exceed one-half of your optional life insurance amounts. Evidence of Insurability (EOI) is required for amounts over $50,000, and coverage is not effective until approved by The Standard. Please note that for new hires, you have 30 days from your date of hire to elect up to the $50,000 Guaranteed Issue amount without EOI. After the initial 30 days, any amount requested will be subject to EOI.

Note: If employee or spouse coverage is elected in an amount that exceeds the Guaranteed Issue amount or an enrollment form is signed more than 30 days after becoming eligible for coverage, this insurance will be effective on the date The Standard agrees in writing to insure that person. The Standard will require the person to satisfy the EOI requirement before it agrees to insure him or her.

Child(ren) Optional GTL Insurance

A $10,000 optional group term life insurance coverage is available for your eligible dependent child(ren) regardless of whether you buy optional life insurance coverage for yourself. You pay the same monthly amount regardless of how many of your eligible dependent children are covered. Evidence of Insurability (EOI) is not required for this coverage.

Child(ren) Optional GTL Rates*

Coverage per child	$10,000
Cost per month	$0.60
*To age 26	

Employee Optional Accidental Death & Dismemberment Insurance (AD&D)

Employee optional AD&D insurance is available in amounts equal to one to six times your annual base salary. The cost is $0.028 per month for each $1,000 of coverage. EOI is not required for this coverage.

Disability

Short-Term Disability (STD). After you have completed one full year of service, STERIS provides salary continuation if you are unable to perform the essential functions of your job due to a non-occupational illness or injury. Short-Term Disability payments begin on the fifteenth consecutive calendar day of absence. Generally, employees must use any earned but unused Paid Time Off (PTO) during the waiting period and before receiving disability payments. If an employee does not have enough PTO available to satisfy the waiting period, the employee will complete the waiting period at no pay. A professional medical management service reviews and approves applications for STD. Medical certification from your doctor validating your inability to work must be provided. The STD payment is 75 percent of your base pay beginning on day fifteen and continuing through day 90 of your disability and may be subject to a maximum weekly benefit amount. The next 90 days of approved disability are paid at 60 percent of your base pay and may be subject to a maximum weekly benefit amount. STD must be approved and medical certification from your doctor validating your inability to work must be provided. Group health benefits may be continued through the STD period. The regular payroll deduction(s) are deducted from your STD payments. Please contact your Human Resources Representative for further information.

Long-Term Disability (LTD). You are eligible for LTD coverage after 30 days of your hire into an eligible position. If you have a disability which continues past 180 days and you are unable to return to work or perform the essential functions of your job, you may apply for Long-Term Disability benefits. Approval must be granted by the Insurer to qualify for this benefit. If approved for LTD, the disability payment will be paid at 60 percent of your eligible pay and may be subject to a maximum monthly benefit amount. If you are eligible for benefits from other sources (such as Social Security, public pension and Workers' Compensation), your disability benefits may be reduced. If you are approved for LTD and you become disabled prior to age 62, you may apply for a "Waiver of Premium," which provides you with continuing basic and optional (if enrolled prior to disability)

life insurance at no cost to you. When you reach this point in a disability leave, group health benefits may be continued as provided for under COBRA and your employment with STERIS may cease. LTD benefits are subject to pre-existing condition limitations as described in the plan certificate. LTD benefits coordinate with STD payments once you have completed one full year of service.

STERIS Corporation 401(k) Plan

The STERIS Corporation 401(k) Plan provides you with a convenient and effective way to build savings for retirement, while offering current tax advantages. The more money you contribute to the plan, the lower your current taxable income and the larger your retirement savings may be.

Eligibility. You are eligible to participate in the 401(k) plan on the first day of your payroll period that begins after you have been employed for 90 days. You may contribute between 1 percent and 50 percent of your pay on a pre-tax or Roth 401(k) after-tax basis, subject to Internal Revenue Service (IRS) limits* (in 2016, eligible pay is limited to $265,000 and the maximum company match is $9,275). The IRS limit on salary deferral contributions is $18,000. Employees age 50 and older in 2016 may contribute an additional $6,000 in catch-up contribution for a total of $24,000. If you are rehired as an eligible employee and had previously met the Plan's eligibility requirements, you are able to participate in the Plan immediately upon rehire.

Enrollment. As a new hire, you will be mailed an enrollment notification packet from Vanguard 45 days after your hire date. The information contained in this packet will assist you with decisions about the STERIS 401(k) Plan and explains the enrollment process. The 401(k) Summary Plan Description (SPD), Qualified Default Investment Alternative (QDIA) and Safe Harbor Notice will be included in the packet. For enrollment questions, you can contact Vanguard at www.vanguard.com or via a toll-free voice response phone system at 1-800-523-1188.

Matching Contributions. To help you reach your retirement goals, STERIS will match your contributions to the Plan each payroll period. The matching contribution is 100% of the first 1% of eligible pay you contribute to the Plan and 50% of the next 5% of eligible pay you contribute to the Plan, for a total match of 3.5%. The best way to take full advantage of this benefit and maximize your company match is to contribute at least 6% throughout the year. Contributions that you make in excess of 6% of your pay for the payroll period are not matched.

Automatic Enrollment and Automatic Increase. If you do not take steps to enroll or opt-out of participating in the 401(k) Plan, you will be automatically enrolled to defer 3% of your pay on a pre-tax basis, effective on the first payroll period that begins after you have been employed for 90 days. Beginning in the year following employment, employees automatically enrolled at 3% will be automatically increased by 1% each July until reaching a 6% contribution rate, unless you choose to opt-out. If you do not provide an investment direction as to how contributions made on your behalf should be directed, then the contributions will be directed to the Qualified Default Investment Alternative (QDIA).

Rehires. If you are rehired and were previously eligible to participate, you will be eligible to participate immediately on rehire. You will be automatically enrolled in the Plan effective with the first payroll period that begins after your rehire date. The automatic increase provisions apply.

The plan offers:

- Immediate 100 percent vesting of your contributions and the Company match
- Ability to select salary deferral contributions that are pre-tax, Roth 401(k) after-tax or a combination of both
- The option to change your contribution percentage each pay
- The option to change your investment mix at any time

Investment Choices. The 401(k) service provider is Vanguard. To assist you with investment selection, Vanguard offers a variety of advice and guidance options that can tell you how much you should save, which investment options are suitable for you, and even what to do with any money you have outside your retirement plan. And no matter how simple or complex your situation is, you can get help from Vanguard or let Vanguard handle the investing for you. For additional information on these services, visit your plan's online resource center at steris.vanguard-education.com/onestep.

The STERIS Corporation 401(k) Plan is intended to be a self-directed plan under ERISA 404(c). This means that it is your responsibility to determine what investment selections are appropriate for you and to monitor your investment options and investments. Additionally, investing in a single company like the STERIS Corporation Company stock fund may be more volatile compared to other investment options offered by the plan, which are invested in several companies. Because you have the right to make your own investment decisions, plan fiduciaries are relieved of liability for any loss resulting from your investment decisions and instructions.

Withdrawals. Because the plan is intended to help you save for retirement, withdrawals of funds are allowed only in the event of termination, retirement, permanent disability, reaching age 59 ½ (even if still employed) death or qualified financial hardship (subject to certain restrictions).

Note: Most withdrawals are subject to taxation and required withholding. Check with your financial/tax advisor on how this may affect you. Vanguard is required by the IRS to withhold 20 percent of any distribution eligible for rollover if it is not directly transferred to another qualified retirement plan, an IRA or used to purchase an annuity to be paid over a minimum period of the lesser of 10 years or the participant's life expectancy. This withholding will offset a portion of federal income taxes you owe on the distribution.

Loans. Loans are also available from your account if you meet certain criteria. The minimum loan amount is $1,000. The maximum loan amount cannot exceed one-half of your vested account balance or $50,000, whichever is less. You may take only one loan in any 12-month rolling period.

For more information about the STERIS 401(k) Plan, including a Summary Plan Description, please visit the STERIS Intranet or steris.vanguard-education.com/onestep.

*IRS limits are subject to change

Paid Time Off

STERIS's Paid Time Off (PTO) program provides you with both flexibility and individual choice to take time off from work for vacation, holidays, a personal or family illness, doctor appointments, school, volunteerism or other activities.

PTO applies to all eligible U.S. based employees of STERIS as described in the corporate Paid Time Off (PTO) Policy and is determined by years of service as indicated in the allocation table below.

As a newly hired eligible employee, you will receive Paid Time Off prorated according to your hire date. Your annual allocation will increase in January of the year in which the milestone is completed. Advanced scheduling of PTO is subject to facility/department practices for notifications and approval of scheduled and unscheduled time away from work.

In 2016, seven (7) PTO days are designated for holidays and/or for scheduled plant shut-downs. Some STERIS locations/groups have slightly different holiday schedules. You may be required to reserve additional PTO days based on your location.

Paid Time Off Allocation Schedule

Years of Service	FULL-TIME Total PTO Allocation Days	PART-TIME Total PTO Allocation Days
Less than 1 year	Up to 24 days	Up to 12 days
1 but less than 2 years	25 days	12.5 days
2 but less than 5 years	26 days	13 days
5 but less than 8 years	31 days	15.5 days
8 but less than 11 years	33 days	16.5 days
11 but less than 14 years	34 days	17 days
14 but less than 20 years	35 days	17.5 days
20+ years	36 days	18 days

The 2016 Corporate Designated Holiday schedule is:

Friday, January 1, 2016 ..... New Year's Day
Monday, May 30, 2016 ..... Memorial Day
Monday, July 4 2016 ..... Independence Day
Monday, September 5, 2016 ..... Labor Day
Thursday, November 24, 2016 ..... Thanksgiving Day
Friday, November 25, 2016 ..... Day after Thanksgiving
Monday, December 26, 2016 ..... Day after Christmas

Several states and local governments have enacted legislation regarding PTO entitlement. STERIS will comply with all applicable laws covering PTO programs. For additional information, please refer to the STERIS Paid Time Off Policy located on the STERIS Intranet under the Human Resources Community web page, or ask your designated Human Resources Representative.

Business Travel Accident Insurance

This program provides additional benefits to you (or your beneficiary in the event of your death) while on business-related travel excluding your normal daily commute to and from work.

The policy provides a lump-sum benefit of ten times your base salary up to $500,000 to your designated beneficiary in the event of accidental death while you are on company-related business. This is in addition to any STERIS group term life insurance or accidental death and dismemberment (AD&D) coverage. This policy also provides supplemental benefits due to loss of hearing, limb, eye, speech, finger or loss of mobility (quadriplegia, paraplegia or hemiplegia). Please contact the Benefits Department for specific benefit limits.

Additional benefits under this insurance program include:

- $50,000 medical evacuation benefit and repatriation (applies only if the business trip is more than 100 miles from your primary place of residence)
- $5,000 hospital admission guarantee
- $25,000 spousal benefit while traveling on business with you (provided that such travel by spouse is approved and expensed by STERIS)
- Identity theft benefit

STERIS Tuition Reimbursement

We recognize the importance of educational development for you, our employee, and encourage you to participate in programs that have the potential to benefit both you and the Company through increased knowledge and skills. In support of this commitment, STERIS provides reimbursement for tuition costs of job and/or career-related undergraduate and graduate courses at accredited colleges/universities (not including books or course materials).

The following guidelines apply:

- You must be a full-time employee with 3 or more years of continuous service
- Management and Human Resources approval is required

The reimbursement level is 50% and the maximum annual benefit is $5,250.

Additional information including eligibility rules, reimbursement and course limits, is available in the Tuition Reimbursement Policy Statement on the Human Resources Community web page found on the STERIS Intranet, or you may contact your Human Resources Representative for a copy. This policy may change from time to time.

Additional STERIS Benefits

Workers' Compensation may provide coverage for medical care and lost wages for work-related injury or illness. Benefit levels are based on your wages and the state in which you work.

Unemployment Compensation may provide wage continuation for employees who are terminated through no fault of their own. Benefit levels are based on employee wages and the state in which the employee works.

Social Security and Medicare.* In addition to your deductions, STERIS pays 6.2 percent of your earnings up to the taxable wage cap of $118,500 to the Social Security Administration for Old Age Survivor and Disability Income (OASDI) Benefits. STERIS also pays 1.45 percent of your earnings in addition to your deductions for Medicare. The Medicare rate increases to 2.35% for earnings in excess of $200,000.

*Tax rates and limits are subject to change.

2016 BENEFITS GLOSSARY

Brand-Preferred (Formulary): a brand preferred (or formulary) is a list of commonly prescribed medication selected by healthcare professional based on their clinical effectiveness and cost efficiency. The preferred list is available at www.caremark.com.

Co-Insurance: a percentage you pay and the plan pays for healthcare services up to a certain limit after your deductible has been satisfied for the year.

Co-Payment (Co-pay): the amount you will be required to pay at a physicians' office at the time service is rendered or the amount you pay for a prescription.

Deductible: an annual amount that you must satisfy before the Plan pays for any medical claims. Services which require a co-pay are not subject to the deductible.

Evidence of Insurability (EOI): statement (form) or proof of a person's physical condition, occupation or other factor used in determining eligibility for additional life insurance coverage.

Explanation of Benefits (EOB): a form you may receive after a claim has been processed, explaining the action taken on that claim including the amount paid, the benefits available, reasons for denying payment of the claims appeal process.

Generic Drug: a drug with the same active ingredient as its brand counterpart, which can be manufactured by any pharmaceutical company after the original patent on the brand name drug has expired.

Group Term Life Insurance (GTL): a life insurance policy purchased by an employer for the benefit of its eligible and enrolled employees which pays benefits upon the death of the enrolled individual (employee, spouse, dependent). A term life policy has no cash value.

Guaranteed Issue: the right to purchase insurance without physical examination; the present and past physical condition of the applicant is not considered.

In-network: means that your provider is in the network of providers. Using in-network providers save you money.

Leave of Absence (LOA): a leave from work in instances where unusual or unavoidable circumstances require an extended absence. Reasons include medical-related issues; birth, adoption or foster placement of a child; military duty; jury duty and other personal reasons.

Mail-order Prescription: a long-term supply of medication (usually 90 days) sent directly to the patient through the mail.

Open Enrollment: the annual benefit plan enrollment near the end of each year during which you may change your benefits plan and/or covered dependents for the upcoming year.

Out-of-Network: means a provider not in the network of providers. For healthcare benefits, if your provider is out-of-network, you may pay a higher cost.

Out-of-Pocket Maximum: an annual limit on the maximum amount you will have to pay for medical and prescription drug services beyond the deductible. Co-payments, co-insurance and deductibles accumulate toward your out-of-pocket maximum. After you reach this maximum dollar amount, the plan will pay 100 percent of the remaining expenses, including co-pays. Separate maximums apply for in-network and out-of-network services.

Payroll Deductions: the per pay amount you pay through payroll deduction toward the cost of your benefits.

Pre-existing Condition Limitation: a medical condition where medical advice, diagnosis, care or treatment was recommended or received within a certain period prior to the person's effective date. Pre-existing conditions limitations do not apply to the medical including prescriptions drug plan, but do apply to other benefit plans.

Preferred Provider Organization (PPO): a managed care organization of medical doctors, hospitals and other healthcare providers who secure preferred rates for you and your covered complex conditions.

Specialty Drug: high cost medications that are taken for rare and complex conditions.

Summary Plan Description (SPD): a document that provides important information about, if applicable, your medical, prescription, dental and vision benefits as well as your life AD&D, 401(k) and long-term disability insurance benefits.

STERIS Benefits Department	
STERIS Benefits Connection	www.sterisbenefitsconnection.com USERNAME: STERIS PASSWORD: STEBENEFITS
Help Line	877-354-5755
E-mail	benefits@steris.com
Fax	440-354-7043

Medical Provider	Anthem Blue Cross and Blue Shield (BCBS)
Group Number	003329764
Customer Service	800-749-5473
Website	www.Anthem.com

Prescription Drug Provider	Caremark
Group Number	STERX
Customer Service	800-776-1355
Website	www.Caremark.com

Tobacco Cessation Program	Anthem
Customer Service	800-865-1044

Vision Provider	Anthem Blue View Vision
Customer Service	866-723-0515
Website	www.Anthem.com

Dental Provider	Aetna Dental PPO
Group Number	700380-10-035
Customer Service	877-368-6605
Website	www.Aetna.com

Flexible Spending Accounts (FSA)	Anthem (FSA)
Customer Service	877-233-7040
Website	www.benefitadminsolutions.com

Health Savings Accounts (HSAs)	HealthEquity
Customer Service	866-346-5800
Website	www.healthequity.com/ed/STERIS

Employee Assistance Program (EAP)	Anthem (EAP)
Customer Service	800-865-1044
Website	www.AnthemEAP.com

401(k) Plan	Vanguard
Plan Number	096356
Customer Service	800-523-1188
Website	http://steris.vanguard-education.com/onestep

STERIS

5960 Heisley Road
Mentor, OH 44060-1834 ▪ USA
440-354-2600

EXHIBIT D

Date: 02/24/2017

Under the STERIS plan of benefits, employee participation terminates "if you fail to pay your share of any premium..." Therefore, to avoid termination of health care benefits to which I am entitled under the STERIS benefits program and under the law, enclosed please find $ 112.62 in payment of my bi-weekly contribution to premium for medical coverage.

The eligibility requirements of the STERIS benefits program require only that a participant must be "a regular employee" to be eligible for coverage. Even though I am on strike for better wages and benefits, I remain a "regular employee" of the company under the law.

Signed:

Print Name:

[redacted]

[redacted]

02/24/2017

Pay to the Order of STERIS Corporation

One Hundred Twelve and 62/100 $ 112.62

PNC BANK

Dollars

For Medical/Dental

[redacted]

EXHIBIT E

To: All Technicians and Assistants

From: Mike Briglia

Date: 2/16/17

Re: Update on Contract Negotiations

I wanted to take this opportunity to provide you with MicroClean's perspective on the negotiations and the Technicians decision to strike. Obviously, we are extremely disappointed that the situation has reached this point, especially since we came to the table with a sincere willingness to get a deal done.

However, from the very beginning of the process we realized the negotiations were going to present many challenges. On the first day, the Union presented us with a proposal that was a copy of the "standard" agreement they have with an Association for the construction industry. Upon review, it was apparent that the provisions of the agreement were not applicable to our business and the skill set of our technicians. However, the Union explained to us that they have very little, if any, flexibility to deviate from the standard agreement. because of orders from the International Union and a "most favored nations clause" in the contract. That means that if they negotiate something different with us that the companies in the Association think is better, then our provision would apply to the Association's standard contract. We countered with a comprehensive proposal that provided many if not all the protections contained in the Union's proposal. Our proposal, however, was tailored to our business and your work day.

We subsequently spent many hours at the table, over many days describing MicroClean's business, our client base and our day-to-day operations. The Union acknowledged that there were many provisions that do not apply to our employees or our business. However, they continued to insist that we agree to the standard agreement but negotiate some side exceptions. Still, they conceded they had little flexibility, even in the exceptions.

In the last meeting before yesterday, the Union told us that they needed a response to their wage and benefit proposal. The Union told us they "must have" agreement on the package they presented we could not reach agreement and bargaining over anything else was futile. After careful consideration, we determined that the wage and benefit package the Union proposed is not acceptable. The proposal increases our wage and benefit costs by 55%, and doubles our costs during the life of the first contract. We did, however, offer a serious counter proposal that contained substantial immediate wage adjustments and substantial wage increases as Technicians progress through training. Given that the Union proposed its wage and benefit proposal as a "must have," we felt it best to give our best offer on wages and benefits. The Union flatly rejected our proposal and declared an impasse.

Our proposal is attached (in case you do not already have a copy) and includes the following:

- Increased starting rates;
- Wage progressions for Assistants and Certification, Validation and Calibration Technicians;
- Clearly defined criteria for moving through the wage progressions;
- An initial wage placement of all current assistants and technicians; and
- Maintenance of the current health insurance contributions for the remainder of 2017.

It has always been our objective to provide all of you with a fair and competitive wage and benefit package. We believe we can continue to do so with what we offered last night. Unfortunately, a strike was called. action.

Because of the serious impact it would have on everyone, we want to advise you of your rights and obligations if you chose to remain on strike.

Employees have the legal right to strike. Of course, striking employees will not receive any wages while on strike and do not receive Company paid benefits such as medical insurance. You will receive a notice of your rights to continue medical insurance pursuant to COBRA. You will now be responsible to pay the full cost of the premium. Striking employees also are not eligible for unemployment benefits.

Understand that during this strike MicroClean has an obligation to its Customers and your non-striking co-workers to continue providing service. We will utilize current resources and begin recruiting "permanent" replacement workers to fill your positions. That means that when the strike is over, any permanent replacements would keep their jobs and striking employees would have a right to get their job back only if a position is available. Strikers who are replaced must wait until a job becomes available to be re-employed. Permanently replaced workers would be put on a preferential recall list to be used if and when job openings occur.

Remember, just as employees have the legal right to strike, they also have a legal right to come to work. We want you to know that despite a call for a strike, your jobs will be available to you. We hope you re-consider and come to work.

You should know that if you have signed up as a Union member, the Union has the right to impose discipline against you, including monetary fines for coming to work. The Union, however, cannot fine an employee who resigns his or her membership before crossing the picket line to work.

If you wish to resign from the Union, all you need to do is write the Union a signed letter that says: "I am an employee of MicroClean. I immediately resign my membership in Union, Local 19". You should ail this letter to the Union and you should keep a copy. You should allow a couple of days for mail delivery before you return to work if you do not send it for overnight delivery.

Please understand that the Company is not urging or encouraging you to resign from the Union. This is a matter for each of you to decide. We will not take action against any employee for exercising his or her right to resign from or remain a member of the Union and we do not want to be advised of your decision.

We trust you understand that strikes, of even a short duration, can have a devastating effect on everyone's future. Obviously, we risk losing Customers and consequently jobs. Our goal is to keep both.

EXHIBIT F

LAW OFFICES
SPEAR WILDERMAN
A Professional Corporation
230 SOUTH BROAD STREET, SUITE 1400, PHILADELPHIA, PA 19102
TEL: (215) 732-0101 FAX: (215) 732-7790

WARREN J. BORISH*
SAMUEL L. SPEAR
JAMES F. RUNCKEL
CHARLES T. JOYCE*
BENJAMIN EISNER◊
WENDY CHIERICI*
JAMES KATZ*
MARTIN W. MILZ*
LOIS GARBER SCHWARTZ*
WILLIAM B. SANDERSON, JR.*
NICHOLAS J. BOTTA
SYRETTA J. MARTIN
MELISSA A. LOVETT
F. TIGHE BURNS*
THEODORE P. DiMUZIO

PA BAR EXCEPT:
* PA & NJ BAR
◊PA, NJ & DC BAR

NJ OFFICE:
1040 N. KINGS HIGHWAY
SUITE 202
CHERRY HILL, NJ 08034
(856) 482-8799 FAX: (856) 482-0343

BRUCE E. ENDY
Of Counsel

LEONARD SPEAR
1923 - 2003

LOUIS H. WILDERMAN
1909 - 1993

February 22, 2017

Via Electronic Mail (corradij@jacksonlewis.com)
Controlled Environmental Systems, Inc./Micro-Clean/STERIS
c/o Jeffrey J. Corradino
Jackson Lewis P.C.
220 Headquarters Plaza
East Tower, 7th Floor
Morristown, NJ 07960-6834

RE: Sheet Metal Workers Local 19 – Group Health coverage for Controlled Environmental Systems, Inc./Micro-Clean/STERIS ("Micro-Clean") employees represented by Sheet Metal Workers Local 19

Dear Mr. Corradino:

As you know, this law firm represents the Sheet Metal Workers Local 19. We are writing to draw your attention to important issues relating to the group health coverage of Micro-Clean employees represented by Local 19 who are currently on strike against Micro-Clean.

We have been informed that Micro-Clean may be in the process of terminating the group health coverage of these employees. Is this true? Conflicting information is circulating. Please clarify Micro-Clean's intentions and provide the basis for any planned termination. Please also clarify the intended effective date of any termination or suspension.

Second, Local 19 expects that if benefits are suspended or terminated, Micro-Clean will extend to these individuals appropriate notice of their right to continue their coverage under COBRA. As you know, a job action, including a strike, constitutes a COBRA-qualifying event under the relevant regulations. **Treas. Reg. §54.4980B-4, Q + A2.** ("a strike ... is a termination or reduction of hours that constitutes a qualifying event...")

Accordingly, please understand that inappropriate benefit termination or failure to afford the striking employees the opportunity to continue their coverage under COBRA will result in an immediate action to compel compliance with applicable law, a part of which will be an application for attorney's fees.

In addition, and as you also know, under COBRA the affected employees must be given sixty (60) days to elect COBRA continuation coverage from the later of the effective date of termination or the date the notice is received. **ERISA section 605(a)(1).**

I look forward to hearing from you, and please contact me should there be any disagreement about these fundamental provisions of applicable law. Thank you for your immediate attention.

Sincerely yours,

Benjamin Eisner

BE:dd

cc: Gary Masino
Affected Sheet Metal Workers Local 19 members

EXHIBIT G

FORM EXEMPT UNDER 44 U.S.C 3512

INTERNET
FORM NLRB-501
(2-08)

UNITED STATES OF AMERICA
NATIONAL LABOR RELATIONS BOARD
CHARGE AGAINST EMPLOYER

DO NOT WRITE IN THIS SPACE

Case	Date Filed

INSTRUCTIONS:
File an original with NLRB Regional Director for the region in which the alleged unfair labor practice occurred or is occurring.

1. EMPLOYER AGAINST WHOM CHARGE IS BROUGHT

a. Name of Employer
Controlled Environment Certification Services, Inc./Micro-Clean/STERIS

b. Tel. No.

c. Cell No.

f. Fax No.

g. e-Mail

d. Address *(Street, city, state, and ZIP code)*
117 N. Commerce Way
Bethlehem, PA 18017

e. Employer Representative
Jeffrey Corradino, Esq.
973-451-6311
corradij@jacksonlewis.com

h. Number of workers employed
37

i. Type of Establishment *(factory, mine, wholesaler, etc.)*
Service

j. Identify principal product or service
Cleanroom certification, decontamination, calibration

k. The above-named employer has engaged in and is engaging in unfair labor practices within the meaning of section 8(a), subsections (1) and *(list subsections)* 8(a)(1) & 8(a)(3) of the National Labor Relations Act, and these unfair labor practices are practices affecting commerce within the meaning of the Act, or these unfair labor practices are unfair practices affecting commerce within the meaning of the Act and the Postal Reorganization Act.

2. Basis of the Charge *(set forth a clear and concise statement of the facts constituting the alleged unfair labor practices)*

On or about February 16, 2017, the employer discriminated against employees engaged in union activity by terminating their healthcare benefits.

10(j) relief is requested.

3. Full name of party filing charge *(if labor organization, give full name, including local name and number)*
Int'l Assn. of Sheet Metal, Air, Rail & Transportation Workers (SMART), Sheet Metal Workers Local 19

4a. Address *(Street and number, city, state, and ZIP code)*
1301 S. Columbus Blvd.
Philadelphia, PA 19147

4b. Tel. No. 215-952-1999

4c. Cell No.

4d. Fax No.

4e. e-Mail

5. Full name of national or international labor organization of which it is an affiliate or constituent unit *(to be filled in when charge is filed by a labor organization)* Int'l Assn. of Sheet Metal, Air, Rail & Transportation Workers (SMART)

6. DECLARATION
I declare that I have read the above charge and that the statements are true to the best of my knowledge and belief.

By _____ Martin W. Milz, Attorney for Local 19
(signature of representative or person making charge) *(Print/type name and title or office, if any)*

Address 230 S. Broad St., Suite 1400, Philadelphia, PA 19102

2/24/2017
(date)

Tel. No. 215-732-7790

Office, if any, Cell No.

Fax No. 215-732-7790

e-Mail
mmilz@spearwilderman.com

WILLFUL FALSE STATEMENTS ON THIS CHARGE CAN BE PUNISHED BY FINE AND IMPRISONMENT (U.S. CODE, TITLE 18, SECTION 1001)

PRIVACY ACT STATEMENT

Solicitation of the information on this form is authorized by the National Labor Relations Act (NLRA), 29 U.S.C. § 151 *et seq.* The principal use of the information is to assist the National Labor Relations Board (NLRB) in processing unfair labor practice and related proceedings or litigation. The routine uses for the information are fully set forth in the Federal Register, 71 Fed. Reg. 74942-43 (Dec. 13, 2006). The NLRB will further explain these uses upon request. Disclosure of this information to the NLRB is voluntary; however, failure to supply the information will cause the NLRB to decline to invoke its processes.